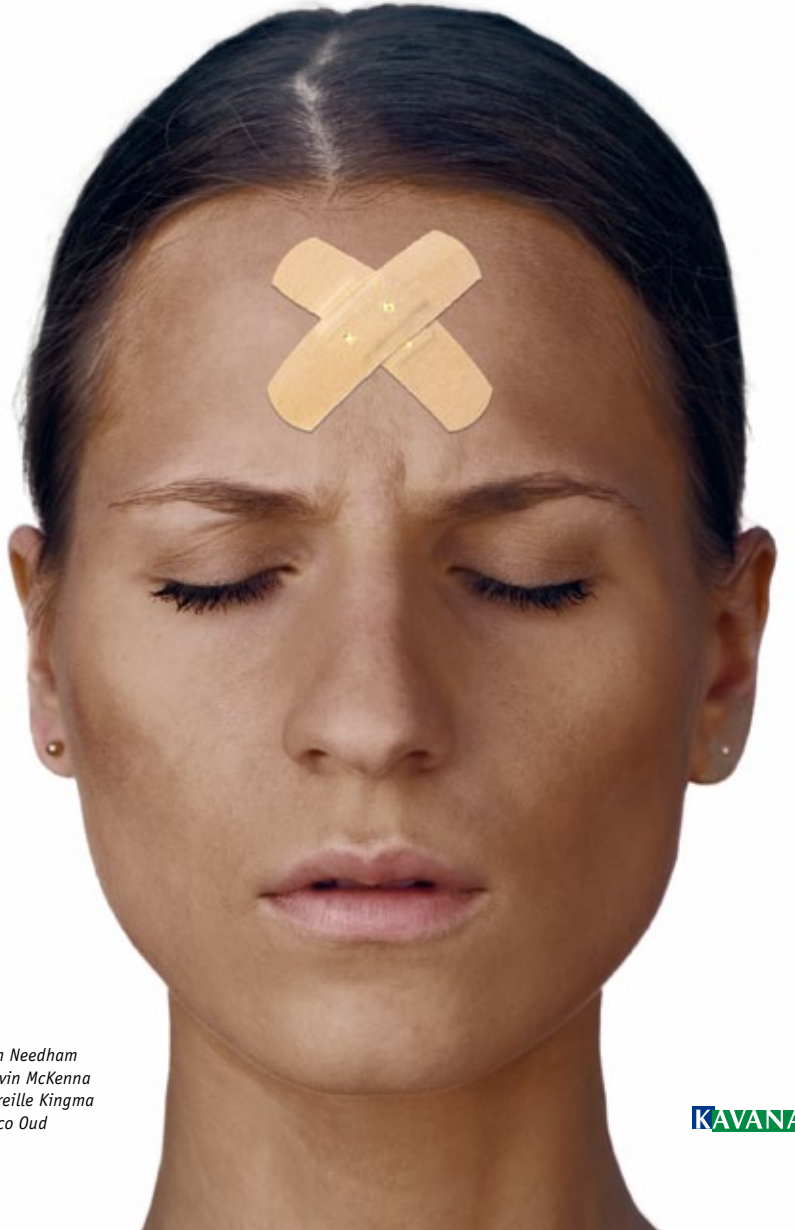
Third International Conference on

Violence in the Health Sector

Linking local initiatives with global learning



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Violence in the Health Sector

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Linking local initiatives with global learning

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Preface

Following two successful conferences in Amsterdam entitled *"Together, creating a safe work environment"* (2008) and *"From awareness to sustainable action"* (2010) this present conference takes us 7696 kilometres in a south-westerly direction to the Canadian City of Vancouver in British Columbia. The theme of the present conference is *"Linking local initiatives with global learning"* which represents the wish to bring persons from the four corners of the globe together to present and share their work.

Canada's third largest city is nestled in the rain forest of the Pacific Northwest, between the Coastal Mountain range and the Salish Sea. One of the world's most beautiful and liveable cities, it played host to the 1986 World Exposition and the 2010 Winter Olympics. Vancouver is known for its relaxed social attitudes, and its willingness to put new ideas into practice, such as the founding of the first North American *"safe injection"* site, and the deinstitutionalization of mental health care. Intolerance of violence in the workplace was enshrined in the legislation of British Columbia in 1993. Since then, there have been many collaborative initiatives on preventing violence in health care, with employers, professional associations, unions, clinicians, safety specialists, government and regulators collectively working together to solve problems.

That spirit of collaboration was embedded in the notion of the conference, a term itself derived from the Latin word *"conferre"* - the terms *"ferre"* (to carry, to bear, to bring, to tell) and *"con"* (together). meaning to bring together, carry, convey, discuss, debate, confer. Dictionary definitions of conference include: the act of conferring in a formal meeting for consultation, a meeting for consultation or discussion, an exchange of views, or a formal meeting of people with a shared interest, typically one that takes place over several days. Even in (some) non-European languages the concept of the term conference seems very similar. In the Chinese language for example the term for conference會議 (huìyì) comprises the two characters會 (gathering or coming together, meeting) and 議 (debating, discussing, criticizing, judging) and the Korean word for conference 회의 (ho-i u-i) – which was imported directly from the Japanese or Chinese language – means to gather in order to exchange opinions or to discuss. The ultimate aim of any conference is to provide a more solid knowledge base in order to make informed strategic decisions and initiate or reinforce programs addressing identified challenges to people and/or systems.

These dictionary definitions sit comfortably with the objectives of this year's program for the Violence in the Health Sector conferences in which we offer participants the opportunity to gather, to consult, to discuss, to critique, and to evaluate. This process of critical appraisal is necessary given the theme of the present conference *"Linking local initiatives with global learning"*. Some initiatives may work well within a local context, but may need adaptation for implementation

in settings where other legal, cultural, or economic conditions prevail. Therefore, participants are invited to debate critically the global applicability of initiatives. But above all we hope that the conference participants will be inspired by the presentations and will return home with a wealth of ideas to respond more effectively to their local challenges.

Since the conferences in 2008 and 2010, the catalogue of sub-themes has been revised in order to incorporate as many patterns of aggression/violence in healthcare as possible. Subsequently, this conference incorporates all manifestations of aggression and/or violence, irrespective of who is perpetrator or victim (staff, service user, co-worker, others) including:

- Verbal aggression/violence
- Physical aggression/violence
- Sexual intimidation/harassment
- Psychological aggression/violence
- Horizontal/lateral aggression/violence, such as bullying, mobbing and intimidation
- Financial abuse
- Organizational/hierarchical aggression/violence.

The conference also explores the many impacts of aggression and/or violence within healthcare including:

- Physical/Injury impacts of aggression/violence
- Emotional/Psychological impacts of aggression/violence
- Financial impacts of aggression/violence
- Service-related impacts of aggression/violence
- Professional, legal and ethical impacts of aggression/violence.

The conference devotes special attention to informed initiatives and solutions to aggression and/or violence within healthcare including:

- Creating cultures that minimize aggression and violence
- The minimization/reduction of seclusion, restraint and coercive measures
- Engaging with service users in seeking solutions
- Education and training
- Quality safety and risk reduction initiatives
- Policy/guidance on good practice initiatives.

Another advancement to the present conference is the integration of special workshops by invited experts in their field:

- Prof. Dr. Christopher D. Webster & Dr. Hy Bloom (Canada): “Who says you can’t assess who is at risk to commit workplace violence? The ERA-20”
- Prof. Dr. Christopher D. Webster & Dr. Hy Bloom (Canada): “Who says you can’t immunize the workplace against outbreaks of violence? The WRA-20”
- Dr. Lynn van Male (USA) & Mr. Kevin McKenna (IRL): “Transatlantic Collaboration in Evaluating the Science and Effectiveness of Training”

- Dr. Kelly Watt, Dr. Stephen Hart, and Mr. Richard Hart (Canada): "Strategies for Preventing, Screening, Assessing, and Managing Violence Risk in the Health Sector"
- Dr. Brodie Paterson (UK) & Mr. Kevin McKenna (IRL): "Seeking Consensus of Best Practice in Training Provision - a Pan-European Effort"
- Dr. Werner Tschan (Switzerland): "Sexual violence in healthcare: Intervention and prevention"

Occasionally the conference organization receives queries – especially from academic institutions – regarding the procedure for the selection of abstracts to be presented at the conference. Each abstract is submitted for peer review to members of the International Scientific Committee. Each abstract is anonymously adjudicated by at least three members of the committee. Abstracts are evaluated according to the following criteria:

- relevance to the conference theme,
- interest to an international audience,
- scientific and/or professional merit,
- contribution to knowledge, practice, and policies, and
- clarity of the abstract

Following the evaluation of each submission, the Organization Committee assesses the merit of each individual abstract and deliberates on the acceptance, the rejection or - occasionally - on provisional acceptance pending amelioration of the abstract. On applying this procedure, the Organization Committee endeavours to do justice to all submitters and to the Conference participants, who are entitled to receive state of the art knowledge at the Conference.

In total we did receive 271 abstracts, of which 31 (12%) were rejected, 40 were withdrawn due to financial reasons or not getting a visa, 21 were not included in the program and the proceedings due to not registering after all, and hence it resulted in 180 accepted presentations.

Many participants of previous conferences have noted that the publication of Conference Proceedings is a valuable complement to the Conference. Here again, the Organization Committee strives for a high quality publication.

We extend a warm invitation to all participants to consult enthusiastically, engage in informed debate, and to appraise critically presented work, while making the most of the social, recreational, and tourist activities offered in the vibrant City of Vancouver.

Acknowledgements

Supporting organizations

We would like to thank the following supporting organizations, for their encouraging and friendly support of the conference:

- American Nurses Association (ANA)
- Australasian Society for Intellectual Disability (ASID)
- BC Government and Service Employees' Union (BCGEU)
- Union of Psychiatric Nurses (UPN)
- British Columbia Nurses' Union (BCNU)
- British Institute of Learning Disabilities (BILD)
- Canadian Nurses Association (CNA)
- Centre of Education and Research, St.Gallische Kantonale Psychiatrische Dienste – Sektor Nord, Switzerland (COEUR)
- Canadian Federation of Nurses Unions (CFNU)
- Dundalk Institute of Technology (DKIT)
- Dutch National Nurses' Organization NU'91
- Health Sciences Association of BC (HSABC)
- Hospital Employees' Union (HEU)
- International Association for Healthcare Security & Safety (IAHSS)
- Institut universitaire de formation et de recherche en soins - IUFRS
- Interior Health (IH)
- Manitoba Nurses Union (MNU)
- Northern Health (NH)
- International Alliance of Patients' Organizations (IAPO)
- International Confederation of Dietetic Associations (ICDA)
- International Confederation of Midwives (ICM)
- International Council of Nurses (ICN)
- International Hospital Federation (IHF-FIH)
- International Pharmaceutical Federation (FIP)
- IntraHealth International
- Northern Health (NH)
- ProActive ReSolutions
- Providence Health Care (PHC)
- Provincial Health Services Authority (PHSA)
- Public Services International (PSI)
- Saskatchewan Union of Nurses (SUN)
- Sigma Theta Tau International (STTI)
- Vancouver Coastal Health (VCH)
- Vancouver Island Health Authority (VIHA)
- Workplace Health at Fraser Health Authority (WHFHA)
- WorksafeBC
- World Confederation for Physical Therapy (WCPT)
- World Medical Association (WMA)

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- Elizabeth Adams (ICN)
- Clarisse Delorme (WMA)
- Odile Frank (PSI)
- Nico Oud (Oud Consultancy – Conference Organiser)

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- Andrea Lam (VCH)
- Ben Cheng (VCH)
- Brenda Myers (WCPT)
- Christiane Wiskow (ILO) (informal supporting organization)
- Constance Newman (IntraHealth International)
- Dailaan Shaffer (PHC)
- Dan Murphy (UPN)
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- Erin Thomsen (SUN)
- Esther W. de Vries (NU'91)
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- Isabelle St-Pierre (Université du Québec en Outaouais, representing CNA)
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- Shannon Campbell (IHANH)
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Scientific committee

Many thanks go also to the members of the scientific committee:
- Ms Elizabeth Adams (Switzerland)
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- Dr. Nashat Zuraikat (Jordan)

"Waive the fee" supporting organizations

We are also especially deeply indebted to the following organizations which generously provided financial support for the *"waive the fee fund"* to help to enable 37 conference presenters from about 18 financially less wealthy countries (Cameroon, Egypt, Fiji Islands, India, Indonesia, Iran, Jordan, Mexico, Nepal, Nigeria, Pakistan, Pakistan, Philippines, Russia, Serbia, South Africa, Thailand, Uganda) to attend the conference. In this way it was indeed possible to bring persons from the four corners of the globe together to present and share their work.
- British Columbia Nurses' Union (BCNU)
- Canadian Federation of Nurses Unions (CFNU)
- Centre of Education and Research (COEUR), St.Gallische Kantonale Psychiatrische Dienste – Sektor Nord, Switzerland
- Health Sciences Association of BC (HSABC)
- Institut universitaire de formation et de recherche en soins (IUFRS), University of Lausanne, Switzerland
- Manitoba Nurses Union (MNU)
- Oud Consultancy & Conference Management
- Saskatchewan Union of Nurses (SUN)
- Sigma Theta Tau International (STTI)
- Union of Psychiatric Nurses (UPN)
- Worksafe BC

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Chapter 1 - Keynote speeches and invited workshops

Report from the World Medical Association (WMA)

Keynote speech

Mukesh Haikerwal
Australian Medical Association, chair of the World Medical Association (WMA) Council, Australia

Dr Mukesh Haikerwal the Chair of Council of the World Medical Association in Melbourne's Western Suburbs where he has practised for since 1991. He was the 19th Federal President of the Australian Medical Association (2005-2007), following two years as Federal Vice President and, prior to that, five years on the board of AMA Victoria -two years as Victorian State President (2001-2003). He was the founding Chair of the Westgate Division of Family Medicine (1993-1997)

He is currently working with the National e-Health Transition Authority (NEHTA) apprising the Public, Government the Media and in particular the Clinical Health Professional community of the benefits of the vital role of IT in health care an enabler of reform and sustainability.

Between February 2008 and June 2009 he was appointed a Commissioner to the National Health and Hospitals Reform Commission by the Prime Minister and Minister for Health. In June 2009 he was appointed a Professor in the School of Medicine in the Faculty of Health Sciences at Flinders University in Adelaide, South Australia.

He commenced as Chair of the beyondblue National Doctors' Mental Health Program and the General Practice Data Governance committee in July 2009. Internationally, he has been appointed in 2011 as Chair of the World Medical Association (WMA) Council.

He was awarded Honorary Fellowships by both the Australian Medical Association (2005) and the Royal Australian College of General Practice (2007) as well as being presented with the Australian Medical Association President's Award in May 2009. In October 2009 he was made an Honorary Life Member of the Royal Australian College of General Practitioners.

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Assaulting behavior: A personal story about the violence no one should experience at work

Keynote speech

Kelly R. McLean (USA)

Summary

This keynote is based on my personal experiences related to the violent assault I suffered at the hands of a patient on an acute inpatient psychiatric unit while working as a registered nurse on August 18, 2010. My injuries include permanent damage to my cervical & lumbar spine, jaw & right eye as well as a traumatic brain injury and some resulting psychological issues stemming from the assault itself. The recovery process has been ongoing both physically and psychologically since the assault. I returned to work for a period of 7 months (after being out for almost four months) and was reassigned to the chemical dependency/detox and rehabilitation unit.

Although the physical violence experienced from the initial assault by the patient was both physically and emotionally devastating, the subsequent maltreatment by some colleagues and certain members of the hospital administration was something quite unexpected and equally disturbing, if not more. I will share my experiences and offer my ideas and thoughts on how workplace violence in healthcare can manifest in different ways and why this issue is worthy of more attention, discussion, education and action.

I currently spend much of my time attending follow up appointments with various doctors and providers. I have been fortunate to do some public and keynote speaking on my personal experience and about workplace violence in healthcare. I continue to try to find ways to draw attention to this issue as I do not believe it receives the attention it deserves.

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The ICRC's "Health care in Danger" project

Keynote speech

Robin M. Coupland FRCS
Medical Adviser, Assistance Division, International Committee of the Red Cross (ICRC), Australia

Robin Coupland is a medical adviser in the International Committee of the Red Cross (ICRC). He joined the ICRC in 1987 and worked as a field surgeon in Thailand, Cambodia, Pakistan, Afghanistan, Yemen, Angola, Somalia, Kenya and Sudan. He has developed a health-oriented approach to a variety of issues relating to the design and use of weapons.

A graduate of the Cambridge University School of Clinical Medicine, UK, he trained as a surgeon at the Norfolk and Norwich Hospital and University College Hospital, London. He became a Fellow of the Royal College of Surgeons in 1985. He is the holder of a Graduate Diploma in International Law from the University of Melbourne in Australia.

As part of his current position he has focused on the effects of weapons both conventional and non-conventional. He has developed a public health model of armed violence and its effects as a tool for policy-making, reporting and communication. His current work has two tracks: first, the feasibility of an ICRC operational response in the event of use of nuclear, radiological, biological or chemical weapons; second, improving security of health care in armed conflicts.

He has published medical textbooks about care of wounded people and many articles relating to the surgical management of war wounds, the effects of weapons and armed violence.

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The price of violence: the cost of violence in the health service sector

Keynote speech

Helge Hoel
Manchester Business School, University of Manchester, United Kingdom

Although prevalence levels as well as the character and intensity of experience vary substantially between organisations and between countries, the presence of violence in some form appears to be omnipresent and endemic within the health service sector (ILO/WHO/ICN/PSI, 2002). For those at the receiving end of violent acts, whether physical or psychological in nature, the price paid is often high, taking a toll on their health and wellbeing, affecting job-satisfaction, and indeed their happiness and contentment with life itself (Hogh et al., 2011). Research suggests that such detrimental effects extend beyond the targets of violence, to include witnesses and bystanders (e.g. Hoel et al., 2004). Furthermore, the persons accused of violent conduct, even when such accusations are not upheld, often find their health and career trajectory compromised (Jenkins et al., 2011). In all their manifestations, such consequences of violence represent a drain on organisational resources as targets resort to sickness absenteeism, struggle to keep up to speed and perform to agreed standards, or leave from the organisation altogether. It goes without saying that such and other organisational effects come with a price tag whether accrued as direct or indeed as indirect organisational costs in the form of reduced job-satisfaction, commitment and morale. It is left to society in the end to pick up the remaining costs as it amasses the outlay of soaring bills for medical treatment and medication, unemployment and disability benefits as well as loss of productivity due to premature retirement (Hoel et al, 2002).

When examining the cost of violence some important international new trends in our understanding of workplace violence and its current manifestations need to be acknowledged (Di Martino, Hoel and Cooper, 2003), changes which not least apply to the health sector IILO/WHO/ICN/PSI, 2002). First, research world-wide has revealed a significant shift in attention from a previous focus on physical violence to a new focus on psychological violence such as mistreatment, bulling and harassment. Second, from a previous spotlight on one-off violent incidents, each individual act often of a severe nature, current thinking concentrates more on repeated exposure to acts and behaviour, acts which taken on their own may be rather common and minor in terms of their effect, but cumulatively, when experienced repeatedly over a period of time, take on a very serious and damaging character (Leymann, 1996). Third, whilst research and practice associated with workplace violence and its prevention have arisen from a view that employees have a right to feel safe whilst at work and be protected from damage to their health and well being, recent focus, informed by human rights and anti-discrimination considerations, widens this picture to include issues around employee integrity and respect, with consequences for how the total cost of violence is assessed.

This keynote will critically explore the costs of violence in more detail focusing, in particular, on the costs to organisations, acknowledging that realities may be more complex than what first meets the eye. Although fraught with problems, some examples of cost estimates will be discussed. In this respect one needs to note that beyond the direct and indirect costs accrued as indicated above, there are also intangible costs in the form of damage to reputation, ability to recruit and, as far as the health sector is concerned, the quality of care provided and the safety of clients and patients (Paice & Smith, 2009). Moreover, with most health care organisations representing microcosms of the larger world within which they exist, and, sometimes being even more diverse, it must be acknowledged that factors such as gender, ethnicity, sexual orientation and disability often play a role in incidents of violence (Di Martino & Chappel, 2006; Giga, Hoel & Lewis, 2008), with likely impact on recruitment and attrition. Thus, ability and motivation to manage diversity would affect the accumulated costs of violence. Ironically, organisational attempts to counteract and intervene against the presence of violence come at a considerable price in their own right. However, whilst the gains from such interventions in cost terms are likely to far outweigh the investment, the drive for change will only be successful when statutory obligations and ethical issues are taken into account alongside and in parity with financial considerations.

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Trauma for all - ten years on: Managing the aftermath of violence in the workplace – how far have we travelled?

Keynote speech

Gwen Bonner
Berkshire Healthcare NHS Foundation Trust, United Kingdom

Summary

In 2002 a paper entitled Trauma for all (Bonner et al 2002) described the psychological impact of restraint for staff and patients in a small qualitative study in one inpatient unit in the UK. The themes which emerged from that study were that strong emotions were generated from incidents for both patients and staff, that patients felt distressed and ignored prior to incidents, and isolated and ashamed afterwards. Post incident review was highlighted as helpful for some and unhelpful for others depending upon the way in which it was conducted, but that it was rarely offered following incidents of restraint. Patients and staff also reported that incidents of restraint often evoked distressing memories of previous traumatic events. This presentation will share findings from a subsequent study which expanded upon the Trauma for all themes, as well as highlighting other work which has been developed by the author and colleagues since the original paper was published. Reflections around whether we are any further forward since the original work will be shared.

Background

It is acknowledged that violence in mental health settings is an on-going challenge, with methods of managing aggression and violence being developed and refined over the years. The UK NICE guidance (2005) came some way to offering a framework for physical intervention in the UK and while they highlighted the need for post incident review and support to staff and patients, very little detailed post incident support guidance was offered. This aspect of restraint appears to have remained sketchy in the UK with no consistent agreement around the best methods of managing the aftermath of restraint. Previous research had highlighted that post incident review did not often happen for staff, and when it did it was not always helpful (Bonner 2008; Lee et al 2003; Wright 1999; Nolan et al 1999). Other research suggested that the psychological impact of restraint for both patients and staff was often great, but rarely recognised, and that the overlap of PTSD in this arena must be considered and addressed (Richter and Berger 2006; Needham et al 2005; Bonner et al 2002; Ray et al 1996; Caldwell 1992; Lanza 1992; Whittington and Wykes 1992). There is also some evidence to suggest that being involved in incidents of restraint can reawaken memories of previous violent encounters which have caused further distress to individuals during, and in the aftermath of restraint (Bonner and Wellman 2010; Sequeira and Halstead 2002; Brase Smith 1995; McDougall 1996; Gallop et al 1999).

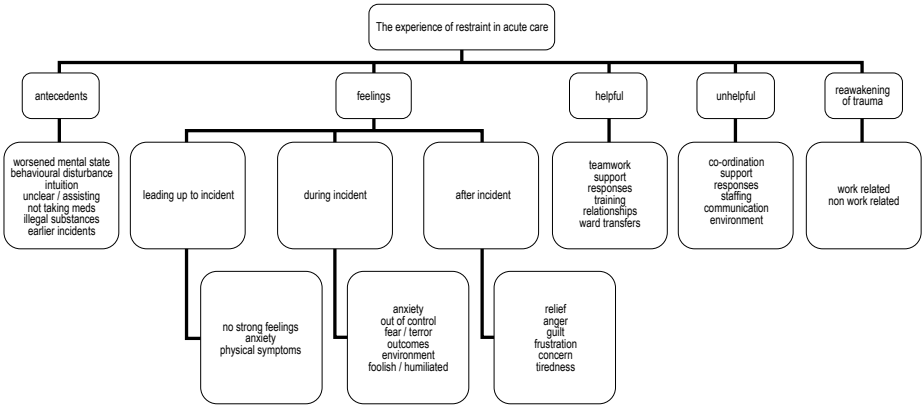
Methods

A mixed methods approach was used to explore the experience of restraint for staff (n=30) and patient participants (n=30) using semi structured interviews to gather qualitative data. These interviews served a dual purpose by providing a post incident review framework which was susceptible to evaluation by the participants and was subsequently evaluated to establish whether this was a helpful approach to implementing post incident review. Focus groups provided additional qualitative data to supplement the individual interviews. In addition, demographic data were gathered to provide a detailed description of the participant groups, and the physical consequences of restraint were captured to ascertain the extent of physical injury to participants who were being interviewed about their experiences. The Trauma Screening Questionnaire (TSQ) (Brewin et al 2002) provided a measurable indicator for participants who warranted further screening for PTSD following the experience of restraint.

Findings

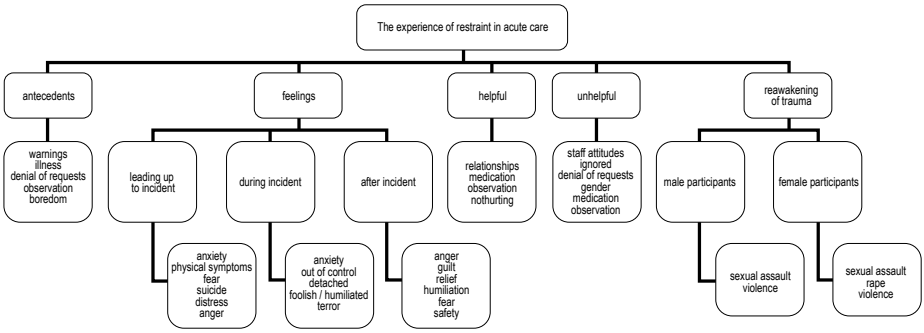
The findings for patient and staff participants illuminated a number of themes related to antecedents which contributed to the restraint incident; powerful feelings before, during, and after the incident; further clarity around what both groups found helpful and unhelpful when physical interventions were employed; and for some participants there was a reawakening of previous traumatic encounters.

Figure 1: Conceptual framework staff



Antecedents for staff included acknowledgement of worsening mental state and history of previous incidents (see Figure 1). For patients, antecedents included perceived ignored warnings of increasing distress, denial of requests, negative experiences of observation, and boredom. Anxiety, a sense of being out of control, and feelings of humiliation were reported by both groups (see Figure 2).
Good relationships were reported as helpful in reducing the psychological impact of restraint and communication was a key theme reported by both groups in terms of managing conflict. 57% (n=34) of participants, equally divided between patient and staff groups, reported that the experience of restraint had triggered memories of previous traumatic encounters, such as assault and rape, which had added to their distress. 40% (n=12) of patient participants and 7% (n=2) of staff were identified as warranting further assessment for PTSD using the Trauma Screening Questionnaire (Brewin et al 2002).

Figure 2. Conceptual framework patients



The evaluation of the post incident review framework used within this study was very positive and offers some guidance for practice. The participants reported that an informal, flexible approach was helpful in reviewing events and identifying potential psychological consequences. A finding which had not been anticipated was the reporting of the psychological impact of verbal aggression in the workplace for staff and this was subsequently examined as a separate project (McLaughlin et al 2010) and related work will be presented separately at this conference.

Managing the aftermath of untoward incidents

The above study found that a flexible, non-threatening approach to post incident review was helpful; and that it was important to ensure that trauma was considered before, during, and following incidents of restraint. Subsequent training programmes included these considerations, for example in pre-registration mental health nursing programmes. Further work was undertaken to develop a workbook for inpatient staff to deliver a consistent approach which used experiential methods and reflection on real life cases for staff teams. As a result of this work it has become increasingly apparent that managing conflict and communication within teams plays a fundamental part to addressing antecedents to aggression and violence, as well as sensitively addressing the aftermath. Supplementary training methods are currently being researched with colleagues to examine the impact of using

forum theatre to consider conflict in the workplace. Early findings are highlighting that this method has a powerful and lasting effect with staff groups.

Trauma for all ten years on…

Many of the themes described above continue to challenge the workforce within inpatient services. Approaches to helping staff address and manage conflict are evolving with a much greater emphasis on understanding communications, as opposed to solely physical intervention training. In the UK the impact of an increasing need to demonstrate quality while managing cost efficiencies has increased the perceived workload burden for inpatient staff. This in turn potentially increases tension and conflict in the workplace which could return staff to a default position of managing aggression in a reactive way. There is a risk that these pressures will prevent staff from taking the necessary time out to engage in conflict and communication skills training and support. It is essential that the lessons learnt in the past ten years are not forgotten in the midst of competing priorities, and that inpatient staff are continually supported through evolving methods to manage this critical area of care.

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Health care professionals as sexual offenders: Victim-Offender-Institution-Dynamic - Understanding – Prevention – Cure

Keynote speech

Werner Tschan (Switzerland)

In this interactive workshop participants are given space for questions and comments, and the participants will learn about the modus operandi of offender-professionals and the resulting victim-offender-institution dynamic. Participants will appreciate that this understanding is the basis of effective intervention strategies - which focuses on the slippery slope concept and provides an understanding of the path to abuse.

Furthermore participants learn that interventions must start as early as possible - preferably before serious boundary violations occur. Lastly participants are offered the opportunity to share the presenter's experiences and preliminary results of how to implement structures to understand, prevent and cure sexual victimization by professionals.

The modus operandi

Why do health professionals commit sexual offenses? For the very same reasons as other criminals do to offend. Health care professionals take advantage of their position and their role – which gives them access to vulnerable patients through their job. They misuse their position of trust and power. Through grooming they „test the waters". Health care institutions are high risk places for sexual offenses. Professionals create the crime scenes for committing the assaults.

The path to abuse illustrates the modus operandi of offenders (Tschan in print). Their manipulative action is always embedded within the institutional context. By their silence, the institution led them proceed on what is called „the slippery slope", where professionals proceed from minor boundary crossings to more severe boundary violations.

We address this as victim-offender-institution dynamic, where the culture of institution always play a crucial role. You can see this for example in the Sandusky case as reported in the media (New York Times, 2012). Despite clear evidence no action was taken by the university's representatives - making it clear today, that many victims could have been avoided. This is a slap in the face of survivors who trusted in the university's statements.

Fantasies are the fuel for offending. Does this statement mean, that we all can become offenders, as we all have fantasies. I do not think so. Most health care professionals really do a great job. Only when you let your fantasies flourish, and then as a consequence cross lines, you're on the slippery slope. If such a thing happens to you, then you should seek help immediately with experienced professionals (Bridges 1998): „With inadequate preparation, trainees run the risk of engaging in destructive behavioural enactments or developing restricted practice styles that stunt the psychotherapeutic process". Case-Supervison could be a place for educating professionals about the risks and how to cope with these challenges inherent in their job.

When offenders start targeting potential victims they have crossed the line. They now are on the path to abuse. Targeting and grooming victims means creating opportunities – the more vulnerable patients are, the more they can become a victim. Some offenders use drugs and sedatives – criminal behaviour which is addressed as DFSA (drug facilitated sexual assault). Some commit their offenses during anaesthesia or shortly after, when patients are still under the influence of narcotics. These substances can blur their mind, they can cause amnesia – so that their memories are disturbed and do not work properly work. Simon has presented one such example in his book (Simon 1996: 111ff). *„ ... B. Noel wakened slowly from sleep induced by the sodium amobarbital administered by her psychiatrist, Dr. Jules Masserman, former president of the American Psychiatric Association. ... this time the awakening was shockingly different. A man was over her, and he was breathing deeply. ... To her horror, she recognized that it was Dr. Masserman"*.

This does on the other hand not mean, that vulnerable patients are per se under greater risk – when their treating professional is ethically correct, he or she will not misuse this dependency; in the contrary they will help the patient sorting out their difficulties (Penfold 1998). In other words: the risk of being abused is determined by the professional only. If a professional has committed boundary violations in the past, the chance that they will do this again are considerably high – we estimated, that 80% of those committing boundary violations are serial offenders (Tschan 2001). Simon underlines that abuses of professional power and authority occur across all of the helping professions. *„None are immune"* (Simon 1996: 115).

How do offenders groom their victims?

In the workshop we look at this question from the other side: what would you do when you want to sleep with someone? Offender professionals use the very same „strategies", e.g. showing interest in the other person,

giving compliments and presents (for health professionals: special attention, special time arrangements, special care, etc.). Offender-professionals create opportunities; some isolate or alienate their patients from friends and relatives, some commit the assault only in their offices (in order to be protected from being seen from outside), just to name a few strategies. Some health care providers address their sexual urges as „therapeutic help" for clients.

What helps in avoiding boundary violations?

Participants get to know the boundary training approach as a remedial technique which is also used for training purposes. The boundary training is a semi-structured cognitive-behavioural oriented training program used for the rehabilitation of disruptive professionals. It must be clear that it is only ever up to the professional to maintain health boundaries; a duty which can never under no circumstances be delegated to patients. Only professionals can violate their code of conduct.

How to help survivors?

The greatest challenge is the handling of the transference issues and the creation of trust and safety. Treatment interventions are based on trauma-sensitive dialectic-behavioural techniques combined with psycho-education (Linehan et al. 2012). Penfold has outlined a fundamental misperception: *„On the whole, our society is not particularly sympathetic to victims, and people often assume that the victim causes her own problem in some way"* (Penfold 1998: 165). By teaching survivors about offender strategies, they realise their own position and their vulnerability. It not their fault. Sometimes a criminal sentence helps associated survivors to really understand what has been done to their loved ones. In Switzerland a couple was attending therapeutic sessions due to their marital problems. The treating psychiatrist engaged in intimate relationship with the woman – leading to the final break of the marriage. Later the physician was sued, but the accusation was cleared. When the case went to Supreme Court and the man was finally sentenced, only then the husband began to understand that his former wife has become the victim of a crime, and he could now forgive her.

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Elimination of restraint and seclusion: road to engagement

Keynote speech

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Abstract

In medical school, students are taught *"first, do no harm."* Yet, in the acute hospital setting, people describe too-frequent experiences of loss of control, fear (and even panic), pain, loss of self-determination, seclusion, restraint, and unwanted medications. Staff members experience fear and assaults and other forms of violence from those they are seeking to serve. Hospital inpatient units can often feel downright dangerous – to both those hospitalized and to those who work there. But we know that before healing can occur, there must be the experience of safety.

During my years as medical director for psychiatry at Salem Hospital in Salem, Oregon, I was fortunate to take part in the miraculous journey of moving to a trauma-informed environment that really was conducive to recovery. Both seclusion and restraint were eliminated, and there was a dramatic decline in the use of involuntary medications (as well as a 30% decline in the use of routine medication). Instead, people were increasingly involved in psychoeducational groups and therapeutic encounters with staff. Injuries (of both staff and those hospitalized) fell to essentially zero, violence melted away, lengths of stay decreased, and financial performance improved. It was a wonderful example of parallel process – recovery for those who came into the hospital and recovery for the hospital service itself.

Our transformation began with a philosophical shift to include the people we were serving in searching for ways we could change the need for control measures. Then we immersed ourselves in understanding the neurobiology of trauma, fear, the fight/flight/freeze response, and realizing how traumatized people perceived our clumsy attempts to be *"safe"* as predatory and controlling. We were astonished to realize that virtually all of the people who came (or were brought) to us had histories of exposure to adverse childhood experiences, and enlightened to discover what that meant for the world view they held. When we changed the lens to one of being trauma-informed, we learned a lot about ourselves; when we changed from *"what is wrong with you"* to *"what happened to you"*, everything else changed too.

In essence, when we changed ourselves and the environment to being really truly *"safe"*, then those we were serving became safe also. Independent of diagnosis, symptoms, age, sex, substance abuse, and history – the variable that was BY FAR in play was….. US.

Subsequently, and in retrospect, the *"us"* that made the difference between fear and safety, between violence and healing, was also the organization itself. We have learned about the effects of chronic stress and trauma on individuals – both those receiving services and those who serve them. Dr. Sandra Bloom, in her recent book Destroying Sanctuary, explains how the extreme stress and trauma that organizations (particularly health and human services) suffer have a similar impact on the organizations themselves. And then… organizations begin to behave like traumatized individuals. Workplace violence, bullying, secrecy, authoritarianism, mistrust, gossip, burnout, low morale, failure – all of these are part of organizational trauma.
Discovering the parallels between traumatized individuals and traumatized organizations is deeply concerning because these organizations are very likely to be less effective as in their clinical mission.

This talk, drawing (with permission) on the work of Dr. Sandra Bloom, reviews the neurobiology of trauma, how trauma-informed care reduces violence, then applies what we know about trauma to organizations and leadership, and explains why organizations behave the way they do.

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Who says you can't immunize the workplace against outbreaks of violence? The WRA-20

Special Workshop

Christopher D. Webster, Hy Bloom
Workplace.calm, inc, Toronto, Ontario, Canada

Abstract

In response to increasing concerns about problematic, disturbing, and violent behaviour in workplaces, various jurisdictions around the world, including most recently, Ontario, Canada, have enacted specific legislation to compel employers to focus on reducing or eliminating the risk for workplace violence in their organizations.

The second part of this workshop on assessing violence risk in the workplace focuses on systemic risk factors that might incite, condone, or passively permit incidents of violence in a work setting.

Towards the end of the talk, the presenters will focus on a recently developed assessment scheme specific to assessing potential risk in the workplace itself (the Workplace Risk Assessment-20 guide, WRA-20).

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Who says a little work never killed anyone?

Special workshop

Hy Bloom, Christopher D. Webster
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Assessing risk for violence by a perpetrator towards potential victims in any situation or venue (i.e. spousal violence, workplace violence, sexual violence, etc.) has been a subject of considerable interest over the last 20 years. Assessing a prospective workplace violence perpetrator's risk for committing a violent act in a workplace has concomitantly increased in importance over the last number of years, as workplaces grapple with trying to understand and prevent violence on their premises.

Numerous highly publicized incidents have captured the attention of both the public and the behavioural sciences community, and have stimulated efforts in trying to understand the causes and motivations that drive perpetrators to act.

The presenters will review different types of workplace violence, and propose a new classification scheme to illustrate the different types and subtypes, including a discussion of instances of workplace violence occurring in healthcare contexts.

Following some discussions about contemporary risk assessment devices and the extent to which these schemes do or do not permit accurate predictions of violence, the presenters elucidate recently-available guides designed to assess for violence risk in the workplace. Attention will be placed on but not restricted to a scheme of their own making – the Employee Risk Assessment-20 guide (ERA-20).

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Health care professionals as sexual offenders: Victim-offender-institution-dynamic. Understanding, preventing, curing

Special Workshop

Werner Tschan (Switzerland)

In this interactive workshop participants are offered space for questions and comments, and the participants will learn about the modus operandi of offender-professionals and the resulting victim-offender-institution dynamic. Participants will appreciate that this understanding is the basis of effective intervention strategies - which focus on the slippery slope concept and provides an understanding of the path to the abuse.

Further participants learn that interventions must start as early as possible - preferably before serious boundary violations occur. Lastly participants are offered the opportunity to share the presenter's experiences and preliminary results of how to implement structures to understand, to prevent and cure sexual victimization by professionals.

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Transatlantic collaboration in evaluating the Product and Process of training staff in the safe effective management of work related aggression and violence within health and social care

Special Workshop

Kevin McKenna, Lynn Van Male
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Background and context

The phenomena of aggression and violence encountered within the clinical setting is a complex issue that presents a unique challenge both to staff and to healthcare providers. The uniqueness of the challenge is embedded in the realization that such behaviours must be understood and managed within diverse health and social care contexts in which duties of care exist both to those receiving and providing services.
Effectively managing the problem, however, is essential as the impact of such occurrences can diminish the quality of working life for staff, compromise organizational effectiveness and ultimately impact negatively on the provision of care services (McKenna 2008).

Notwithstanding the now well acknowledged recognition for effective responses to include multi-faceted organizational approaches, one critical component of any response is the provision of safe effective training to staff in the management of aggression and violence. While the provision of training is a vital component of any comprehensive strategic response, the erroneous assumption that training alone can address this issue is now increasingly acknowledged (McKenna & Paterson 2006). Two major challenges confront organisations in their efforts in commissioning training.

The first of these is the paucity of high quality research as to what constitutes safe and effective practice, which is a serious concern considering the risks of physical and psychological trauma, for both service recipients and providers, inherent in such procedures. The second challenge is ensuring a training response which is congruent with, and can be readily embedded within, the broader corporate governance framework. In effect both these challenges, which can be conceptualised as the 'product' and 'process' of training, need to be addressed effectively for training to contribute meaningfully to the effective management of aggression and violence.

This workshop will present a transatlantic collaboration between Dundalk Institute of Technology (DkIT) and the US Veterans Health Administration (VHA).
The Veterans Health Administration (VHA) is engaged in a programme of sophisticated research investigating the biomechanical metrics of the physical interventions components of training, for the purposes of this workshop referred to as the 'product'.
Dundalk Institute of Technology (DkIT) has developed a well evidenced organisational structure by which training provision can be embedded within an integrated organisational matrix which addresses clinical practice, health and safety, risk management, and corporate policy perspectives, for the purposes of this workshop referred to as the 'product'.

The interactive workshop will present the efforts from both organisations and will showcase the synergistic value adding potential of inter-agency collaboration.

The Veterans Health Administration (VHA) Context: Investigating the 'Product'
The following is a preliminary discussion of work comprehensively reported in a manuscript by Malique Carr, John Lloyd, Eve Hanna, Melville Bradley, Anders Goranson, J. Sid Davis, Chu-Hsiang (Daisy) Chang, and Lynn Van Male.

The VHA's Prevention and Management of Disruptive Behavior (PMDB) program, first written in the late 1970s, has evolved into a multi-module curriculum designed to provide healthcare personnel with the Verbal De-escalation, Personal Safety, and Therapeutic Containment skills necessary to mitigate the violence and injury risk posed by patients engaging in behaviors that undermine the safety of the clinical environment. Utilizing the results of a data-driven workplace behavioral risk assessment, individual facilities across VHA customize the frequency and intensity of the PMDB training they provide their staff to match the demands of their personnel's respective work environments.

The greatest care is taken to ensure the safety of the PMDB training environment, with trainer curriculum fidelity assessments occurring at regular intervals as one element the program's instructor certification standards. The very nature of training physical skills, however, is not completely free from risk of injury. Privitera (2011) asserts that injury occurs when energy, emotional and/or physical, is transferred from a source in amounts that exceed a person's tolerance. Given the marked variability across individuals' ability to tolerate emotional and/

or physical energy, developing a standard physical training product that is completely free from risk of injury for all possible learners is an endeavor fraught with challenge. It was thus with the goal of reducing risk of instructor and participant injury during training courses to the lowest level possible that VHA initiated a rigorous, ongoing course of biomechanical evaluations to inform product improvements in the Personal Safety Skills and Therapeutic Containment elements of the PMDB curriculum.

Aim

The primary purpose of Phase I of the PMDB program's biomechanical evaluation was to assess whether the techniques comprising training product itself unnecessarily elevated the risk of participant and/or instructor injury during product instructional sessions. If the training product itself was determined to be inherently low-risk for musculoskeletal injury, then the secondary aim of the Phase I evaluation was to identify the possible etiology of such potential injuries.

Question

The ultimate question of the Phase I evaluation investigated the safety of the instructional product designed to train healthcare workers the Personal Safety and Therapeutic Containment skills necessary to mitigate risk for injury posed by disruptive patient behaviors.

Methods, Measurements, and Procedures

This evaluation employed a two-part mixed methods design comprised of an expert panel assessment of live, real-time product instruction and of biomechanical laboratory evaluation. It was conducted at the Research Center of Excellence (COE) at the Tampa, Florida, Veterans Affairs Medical Center. The COE houses a state-of-the-art biomechanics research facility designed to support the COE's mission of maximizing rehabilitation outcomes and patient safety.

Expert panel assessment

The expert panel that assessed the Personal Safety and Therapeutic Containment product elements was a multidisciplinary team of doctoral-level professionals: two board-certified ergonomists, one nurse, two board-certified occupational medicine physicians, one industrial/organizational psychologist, and two clinical psychologists. Their combined knowledge represented expertise in occupational nursing, occupational medicine, program evaluation, adult learning processes, physical injury prevention, biomechanics, ergonomics, organizational and industrial psychology, and clinical psychology.

During live, real-time product instruction, the expert panel achieved consensus (Butler & Rothstein, 2007; Polkinghorne, 1983) regarding which product elements warranted biomechanical evaluation in the laboratory. Issues of postural awkwardness; axial loading; range of reach; flexion, extension, rotation, and abduction extremes; force excess; and potential for exacerbation of pre-existing musculoskeletal conditions with respect to product instruction were closely examined during the consensus process.

Product instructor

VHA's national PMDB program Director and four Master Trainers (the designation given to national trainers certified to instruct local personnel in the delivery of the instructional product to other healthcare staff at their facility) modeled the standard to which the product is expected to be instructed across VHA facilities during the expert panel assessment. Two of the four Master Trainers provided biomechanical data during the laboratory portion of the study.

Biomechanical laboratory evaluation

The biomechanical evaluation consisted of capturing and analyzing kinematic and kinetic data associated with product instruction. The ViconTM MX system was used to measure motion, with recorded two-dimensional video images being used to compile a three-dimensional model used for calculating postural loading. Additionally, Delsys®™ EMG electrodes were placed on key major muscle groups utilized in product instruction to monitor muscle activity. A Hybrid III mannequin instrumented with tri-axial and uni-axial load cells was utilized to collect force and impact data resultant from product utilization (see Figure 1).

Figure 1 – Master Trainers engaging in data collection during product utilization in the biomechanical laboratory.

Data analysis

Motion data was analyzed within the proprietary ViconTM Nexus software program to determine whether joint angles and body postures were excessive. EMG data was computed with respect to muscle-specific maximum voluntary contraction. Raw EMG data was processed using Matlab (The Mathworks, Natick, MA). Files contained 10 columns of data, representing simultaneous acquisition of muscle activity data for left and right deltoids, latissimus dorsi, pectoralis major, trapezius and tricep muscle groups, each sampled at 1200 Hz. Fast Fourier Transform was performed to visualize the frequency spectrum of the data, which was subsequently filtered with a 4th order Butterworth band-pass filter with low and high cut off frequencies of 50 and 479 Hz, respectively. Moving average of the filtered data was calculated using a 40msec epoch, which was plotted as a percentage of the maximum voluntary contraction, against time, and maximum values output to a summary file.

Findings and recommendations

Combined results from the expert panel assessment and the biomechanical evaluation demonstrated that, when instructed in the manner modeled by this study's personnel, the training product itself did not represent a source of elevated risk of participant and/or instructor injury during product instructional sessions.
As the training product itself was determined to be inherently low-risk for musculoskeletal injury, the possible etiology of potential participant and/or trainer injuries during product instructional sessions were proposed to include the possibility of trainer *"drift,"* or lack of fidelity to product instructional standards, and unknown and/or unheeded participant pre-existing musculoskeletal conditions.

Product safety recommendations resultant from this study included ensuring all product instructional sessions are staffed adequately by appropriate numbers of certified instructors, regularly assessing trainers for product instructional fidelity, encouraging instructors to rotate between trainer roles to reduce the possibility of acute and cumulative musculoskeletal injuries, and emphasizing to product recipients/instructional session participants that product engagement is at their discretion based upon their knowledge of their own physical and/or emotional energy tolerances.

The methods demonstrated in this study are one model for assessing risks of injury. While this study was unable to conduct biomechanical assessments on multiple live participants during the Therapeutic Containment techniques, Phase II of the PMDB program's biomechanical evaluation will collect data from multiple real-time human sources simultaneously, thus removing the use a mannequin during laboratory data collection.

The Irish Context: Investigating the 'Process'

Within the Irish context, McKenna (2004) reported concerns regarding the structure, content and effectiveness of the training which prompted a thorough review of training. While the extent and findings of this review are beyond the scope of this paper, it served as the impetus for the most critical re-appraisal and radical reorganization of training provision undertaken within the Irish health service.

Two key components of the revision are relevant in the context of this workshop. The first of these was the development of an education programme entitled the Professional Management of Aggression and Violence (PMAV). The programme was developed in a partnership between the Health Service Executive and Dundalk Institute of Technology. The development involved extensive consultation with clinical, professional, academic, and regulatory bodies, in two national stakeholder Delphi exercises. The first of these determined consensus regarding the didactic components of the programme, and the second established consensus as to the 'safety', 'effectiveness', 'acceptability', and 'teachability' of the physical interventions component of the programme.

The overall objective of the PMAV programme is to prepare students from multiple disciplines as instructors who are competent to design and provide training that is needs assessed, fit for purpose, and responsive to the various manifestations of aggression and violence encountered within diverse clinical settings.

The second key component was the development of an organisational model which embeds training provision within a governance framework which adequately and equitably addresses the concerns of all stakeholders. The MOAT framework (McKenna 2005) provides a structure through which instructors systematically evaluate training needs by collaboratively exploring the practice concerns of staff and service managers related to aggression and violence, reviewing service specific health and safety audits and risk management data and considering the prevailing legislative and policy frameworks specific to each service.

From this consultation process, instructors design, develop and deliver training that:
- Responds to safety and practice concerns of services
- Addresses legislative health and safety obligations
- Addresses corporate risk management concerns
- Include only professionally, legally and organizationally permissible interventions
- Is congruent with the organizational philosophy of care

In combination the BSc in PMAV supported by the MOAT framework represents a radical revision of training provision which strives toward a standard of excellence which at the very least, equals best practice internationally.

Implementation and Evaluation

The implementation of the PMAV programme was structured within the Training Implementation and Evaluation (TIE) study, an initiative which was resourced through an innovative multi-agency collaborative funding bid involving the Health Service Executive, the National Partnership Forum, and the Health Research Board.

Aim

The overall aim of this study was to parallel the implementation of a multidisciplinary programme of training in the management of aggression and violence with a systematic investigation of the impact and effectiveness of the training provided.

Question

The ultimate question investigated the effectiveness of this 'process' approach in providing training which is needs assessed, service specific, and fit for purpose.

Study population

The study involved 300 staff from seven diverse services including: Ambulance, Accident & Emergency, Childcare, General Hospital, Intellectual Disability, Older Persons, and Psychiatry

Measurements

The study employed a quasi-experimental design of pre, post, and re-test measures utilizing two stands. [Figure 1]. The first strand utilised a questionnaire series which evaluated the:
- frequency of occurrences encountered by participants,
- extent to which participants formally reported occurrences,
- the emotional impact and physical impact of occurrences,
- the relevance of training to their practice setting,
- the effectiveness of training to their practice setting,
- confidence to manage aggression and violence.

The second strand involved the assessment of the 'safety in practice' and the 'clinical effectiveness' of participants demonstrated performance of interventions from recorded vignettes which were recorded pre and post training, and again at 90 days following the completion of training. See Table 1.

Survey measurements

Occurrences: measured whether respondents had encountered, verbal abuse, threats, and/or physical assaults directed toward them in relation to their work, within the previous thirty days. Occurrences were measured on three occasions, prior to training, 30 days following training, and at 180 days following training.

Reporting measured whether respondents had formally reported occurrences of verbal abuse; threats, and physical assaults. Participants completed the scale on four occasions, prior to training, after training, and on two subsequent occasions at 30 days and 180 days following training, with the post training measurement being of respondents 'intention to report' occurrences in the future.

Figure 1 Quasi Experimental Interrupted time series design

	Pre-Test	Training	Post-Test	Re-Test 1 (Q)	Re-Test 1 (S)	Re-Test 2 (Q)
	Day 1		Day 3-5	Day 30	Day 30	Day 180
Questionnaire Observations N= 300	Qo1		Qo2	Qo3	Qo3	Qo4
Confidence in practice	X		X	X	——	X
Relevance of Training Content	N/A		X	X	——	X
Effectiveness of Training in practice	N/A	PMAV	X	X	——	X
Occurrences within previous 30 days	X		N/A	X	——	X
Impact of Occurrences	X		N/A	X	——	X
Occurrences Reported	X		N/A	X	——	X
Skills Observations N= 30	So1		So2	——	So2	——

Qo = Questionnaire Observations So = Skills Observations

Emotional Impact measured the emotional impact of the most recent occurrences of 'verbal abuse', 'threats', and 'physical assaults' with participants completed the measure on three occasions, prior to training, and on two subsequent occasions at 30 days and 180 days following training.

Physical Impact measured injuries sustained subsequent to the most recent occurrence of physical assault and a second measure compared the absenteeism rate due to all manifestations of aggression and violence in the six month period prior to training and the six month period following training.

Confidence measured respondents confidence in managing both non physical and physical aggression and violence using the Thackrey (1987) confidence scale. Respondents completed the scale on four occasions, prior to training, after training, and on two subsequent occasions at 30 days and 180 days following training.

Relevance measured respondents rating of the relevance of the 'verbal interventions', 'disengagement interventions' and 'containment interventions' delivered during their training to their practice setting. Participants completed this measure on three occasions, immediately following training, and on two subsequent occasions at 30 days and 180 days following training.

Effectiveness measured respondents rating of effectiveness of the 'verbal interventions', 'disengagement interventions' and 'containment interventions' delivered during their training when applied to actual situations in practice. Participants completed this measure on three occasions, immediately following training, and on two subsequent occasions at 30 days and 180 days following training.

Recorded Vignette Measurements

The second strand of the investigated the 'practice safety' and 'clinical effectiveness' of participants demonstrated performance of 'non verbal interventions' from recorded vignettes which were recorded prior to training, following training, and again at 90 days afterwards.

These vignettes measured participants performance of three categories of non verbal interventions namely, 'approach', 'disengagement', and 'containment'. Recorded vignettes were randomized and rated by an international panel of experts who were blind to the training status participants. A specifically constructed rating instrument was utilized to measure experts ratings and the results investigating differences in performance were then statistically analysed.

The presentation will present the findings from both strands of the study and provide the opportunity for discussion of the implications, from professional and organizational perspectives.

Conclusion

This highly interactive workshop will present the significance of both 'Product' and 'Process' evaluations as singular endeavors in their own right, and the potential added value of their contribution jointly toward achieving practice and organizational excellence in providing staff with evidence based best practice training in the management of work related aggression and violence.

The interactive component of the workshop will provide the opportunity to explore:

- Practical demonstrations of work described above
- Biomechanical evaluation of the physical intervention elements of training
- Organizational integration of training
- Opportunities and challenges of international interagency collaborations
- Local applications of the work presented

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Strategies for Preventing, Screening, Assessing, and Managing Violence Risk in the Health Sector

Special Workshop

Kelly Watt, Stephen Hart, and Richard Hart (Canada)

Violence in the health sector is a serious international problem with health care professionals being one of the leading professionals likely to be victims of violence in the workplace. Violence in the health sector has major implications for victims, perpetrators, and society. It is critical for health care professionals to learn strategies to identify warning signs for violence and to respond safely to prevent violence. When concerns about violence risk are raised it is also critical for health care professional to understand how to assess risk for violence and develop strategies to manage this risk.

This workshop will focus on best practices supported by researchers and practitioners around the world in violence prevention, violence screening, and violence assessment and management that will help health care professionals prevent future harm and protect themselves from potential liability. This workshop will be an excellent compliment to other training health care professionals have had in this area and other initiatives they have led to prevent and manage violence risk.

Specifically, Mr. Richard Hart will review a workplace violence prevention program that will help health care professionals to identify warning signs for violence and to respond safely to prevent violence. Dr. Kelly Watt will introduce a violence triage tool that will assist health care professionals in determining whether a risk for violence exists and prioritizing immediate actions. Dr. Stephen Hart will review structured professional judgment guidelines that will facilitate health care professionals decisions about assessing and managing violence risk.

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A European charter for trainers in the prevention and management of workplace violence: Results of a Delphi exercisewithin health and social care

Special Workshop

Brodie Paterson, Kevin McKenna, Vaughan Bowie

Introduction

The European Network for Training in the Management of Aggression (ENTMA) is a not for profit association, which aims to unite and support those involved in the design, delivery, commissioning, evaluation and regulation of training across Europe. Its ambition is to promote evidence based best practice and share experience and expertise in order to achieve practice and organizational excellence in the design, delivery and evaluation of training in the management of aggression within health, education, care and related services.

ENTMA08 evolved from an informal European collaboration between trainers in the management of aggression which had existed since 1998, adopted the name ENTMA in 2004 which was changed to ENTMA08 in 2008 to mark the formation of an international steering group to guide the future of the network. The collaboration has to date involved professionals across a broad range of health, care and related sectors who were engaged in, or associated with training in the management of aggression. The collaboration has provided a forum within which perspectives on the nature, function and methods of training can be exchanged. This has facilitated an exploration of the core values that should underpin training, and sought to establish a shared understanding of good practice in the design, delivery and evaluation of training.

Despite the existence of detailed sectoral guidance regarding the content of training at a European level for some settings such as services for people with mental disorder (Council of Europe (CoE) Steering Committee on Bioethics, 2000) it is clear that training and practice continue to vary significantly across Europe and sometimes within individual states (Whittington et al 2006). It appeared to ENTMA therefore that the development of a 'charter' identifying the principles that should underlie the role and content of training offered an opportunity to establish a Europe wide vision of best practice. Such a charter it is hoped will provide not just a statement of such principles but a document that may by used to identify and challenge poor practice.

This paper will firstly discuss the contemporary background in order that the rationale behind the development of the charter is understood. It will then outline the development process and present the results of the first stage of a Delphi exercise undertaken to establish face and content validity. It will then discuss the implications of such results for the further development of the charter as well as wider practice and policy in this area.

Background

Training forms only one element of the multidimensional strategies that are invariably needed to realize the whole organization, public health based approaches that currently represent best practice in the prevention and management of workplace violence (Bowen, et al. 2011). Consequently misconstruing or misrepresenting training as a panacea perpetuates an unhelpful framing of the issue that can actually hinder the development of more effective strategies (Zarola and Leather 2006, Paterson et al 2010). Training can sometimes be misused by organisations as a means of avoiding facing broader organizational issues such as resource insufficiencies whether in staff numbers, wider skills, the physical environment or the malign influence of toxic and corrupted cultures (Bowie 2011). When such ill-informed initiatives fail, blame can be attributed to the training content, the training provider, or to the participants who are invariably direct care staff. This attribution error conveniently absolves the wider organization or management of responsibility and perpetuates denial of the need for the deeper governance improvements which are actually needed (Bowie et al. 2005, Bowie 2011).

Where the focus of training is primarily on improved crisis management and in particular on physical intervention i.e. restraint, there is at least some research to suggest that such approaches with some training models appear to produce negative results with increases in violent incidents and staff and patient injuries recorded in a number of studies (Leadbetter and Paterson 2010). Training in the prevention and management of violence and aggression is though not a homogenous intervention with huge variation in the frame of the problem used to inform training, how the training provider engages with the service provider, the content and duration of training, and who actually determines 'who is trained to do what' e.g. direct care staff, all clinicians or all clinicians plus managers and/or the CEO (McKenna 2008).

Considerable caution must be exercised in the unqualified assumptions that 'training' in this area will produce a positive results, or at the very least do no harm (McKenna 2008; Stubbs et al. 2009). Unlike some other types of training that at their worst may have little impact, inappropriately conceived and/or poorly designed violence prevention and management training developed and conducted in an inappropriate manner may cause considerable harm which in a worst case scenario could have fatal consequences for the end user i.e. the person being restrained (Bowie in press).

A dominant frame within some organizations is one which perceives the problem as one of staff being potentially injured during assaults and/or their attempts to restrain. Inherent in this assumption is the view which considers this a technical problem amenable to training staff to restrain more effectively such that service users are dissuaded from assault in fear of its consequences (Paterson et al. 2011). Convincing such an organization of the need to embrace deep change in their fundamental values, core working practices, and hierarchies may be perilous for the trainer employed by the organization who risks being ostracized as a function of the conflict between their vision and that of the wider organization.

For an external commercial training provider convincing such an organization that their framing of the problem is ill-informed and that their training needs are often more extensive than those perceived can result in the organization choosing to find an alternative training provider who will proceed with the demands at the lowest cost. Much of this type of training is delivered via standardized scripts, which can be delivered via trainers who have undertaken short 'train the trainer' programs which may not be informed by the detailed consultation and training needs analysis necessary to develop a program that will actually respond to the needs of a particular service, its staff, and its potentially diverse range of service users (Bowie in press).

There are two intrinsic flaws in such approaches. The first is the perpetuation of the perception of physical interventions as a 'skill taught to staff' rather than as an 'intervention done to patients'. Physical interventions need to be understood as a patient focused intervention purposefully employed within a professional care context, which effectively shifts the focus from one of managing aggression and violence to one of professional patient care (McKenna 2008 p60). The second flaw is the application of a 'product' solution i.e. standardised training packages to a 'process' problem, which almost invariably has service specific dimensions requiring an integrated solution nested within a broader violence prevention strategy designed specifically within the context of the organization (McKenna and Paterson 2006).

The pressures of an unregulated marketplace in training in the prevention and management of violence that continues to exist in most settings and countries in Europe are however substantial. This may create ethical dilemmas for trainers whose awareness that ethical issues are present in their overall approach and not just the content of their training appears to vary (Ward and Syversen 2009). Trainers may be aware of the dilemmas involved in physical intervention training e.g. around pain compliance but lack the broader awareness that the framing of the problem, the demands placed on training and the decisions regarding who needs trained in what also have significant ethical ramifications (Ianinska and Garcia-Zamor 2006).

Recognition of the potential dangers of an unregulated marketplace have led to the development of a number of 'accreditation' schemes for training in the prevention and safer management of violence have most notably in the UK. These include a scheme developed by the British Institute of Learning Disabilities specifically for physical intervention training providers in the care sector and a number of qualifications endorsed by UK Government recognized educational accrediting bodies including City and Guilds and Edexcel. Such schemes can be criticized however, the BILD scheme whilst endorsed in English government guidance is not mandatory and actually explicitly eschews any judgments on the physical intervention procedures a given accredited training provider may use. Hence accreditation may offer little real assurance regarding the content of training or its appropriateness in relation to meeting the relevant sectoral or occupational standards or ultimately even its safety.

There is presently no European regulatory mechanism and in many countries no guidance on the suggested philosophy or content of training. In the absence of such guidance there is little to differentiate the more unscrupulous elements of the training industry from those who espouse best practice. A charter developed by ENTMA and endorsed as representing best practice by trainers could therefore fill at least in part the current regulatory gap. It could also alert potential customers of training providers to what currently represents best practice.

The approach taken in the development of the charter involves a modified Delphi approach which to date has involved a) the initial development of the charter by the ENTMA steering group and b) piloting the draft charter to establish face and content validity with a sample of trainers. The results of this first round are reported here with subsequent rounds planned.

Face validity in this context describes the extent to which trainers agree that the charter *appears* to represent what it purports to i.e. best practice in the provision of training in the prevention and safer management of workplace violence (Bowling 2002; Greenwood 2004). While ultimately based on subjective judgments it is important for the charter to enjoy reasonable face validity with the community of trainers involved in the delivery of the training in this area if it is to have any impact (Greenwood 2004). *Content validity* in this context seeks to establish more specifically whether the multiple dimensions of what best practice in this area may involve are adequately represented within the charter i.e. has anything been missed and to exclude any themes considered irrelevant (Greenwood 2004).

The Delphi technique has been used for some decades and is regarded as an effective means of ascertaining group consensus (Black et al. 1999). Utilizing a structured process, the method typically involves a number of structured rounds of consultation with identified experts to arrive at group agreement An implicit challenge to the validity of the process is however by which means expertise in a given area is determined (Hasson and Keeney 2011). Expertise may variously be determined by seniority, years of experience, qualifications or

research undertaken and published (Hasson and Keeney 2011). In this instance given the lack of evidence correlating such criteria with the adoption of best practice a pragmatic and inclusive approach was adopted such that the sample used in the first round were those attending a workshop at the ENTMA trainers conference in Amsterdam in 2010.

Data collection

The draft charter was circulated with respondents asked to rate their agreement using a visual analogue scale to identify their agreement with the charter statements of principle. Qualitative data was also sought via the option for individuals to make comments in relation to any aspect of the proposed charter,

Response rate / sample demographics

As a pragmatic convenience sample the response rate was 100% with a sample size of n=54. The sample was 66% male, 35% female. 92% had trained as an instructor and 98% of those trained were currently practicing as a trainer either part time or full time (sample mean 55% time spent in a training role) suggesting the sample were overwhelmingly active trainers who spent the majority of their time training. More than 50% of the sample had trained in more than one model (range of number of models trained in 1=10+) indicating most had some experience in different approaches to WPV training with respondents identifying a total of 19 different models they had trained in or were using. Their length of experience (not necessarily as a trainer with their current organization ranged form 7 months to 33 years (mean 12 years 2 months). Their mean cumulative experience in a training role was 8 years 6 months (not just their current post or training model) range 2 months - 25 years. 35% (n=19) worked in psychiatry, 25.9% worked with children (social care and CAMHS) (n=14) 22% worked in Forensic secure settings (n=12) 9.3% worked in general hospital settings (n=5) and 5.6% worked in services for people with a learning disability n=3. 63% (n=31) however trained in more than one setting compared to 27.8% (n=15) who trained in more than one setting suggesting that training outside one's original area of practice may be commonplace.

Results and discussion

Respondents were asked to rate their agreement / disagreement using a VAS scale (which provided an analogue ranking of 1-100 with a series of statements covering three broad areas. The VAS ranking used meant that a score of 100.00 represented complete disagreement with the statement and a score of 0.00 complete agreement. See Table 1.

Although broad agreement with most principles was extremely high some variation was evident both in the range of scores and the mean rating. Only two items achieved less than 90% agreement, which is in some respects unsurprising. The two statements that failed to reach this level of agreement were; 'Trainers should strive to integrate training into a broader organisational agenda'. (Mean raking 12.7) and 'training should be located in the context of a professional relationship'. (Mean rating 13.05).

Given the emergent emphasis on the need for whole organisation approaches any lack of agreement is somewhat disquieting but may reflect for at least some trainers their inability to realise such an objective. One respondent noted, however *"what does a trainer do with a 'bad' organization" "which has a different agenda"* and suggested that *"ENTMA provide a model for Management infiltration in order to accomplish integration"*.

The suggestion that training should be located in the context of a professional relationship attracted what is in some respects still a high level of agreement but this was notably less than in other areas. This may however reflect a context in which some trainers may not in fact hold a relevant professional qualification e.g. social work, teaching or nursing (Zarola and Leather 2006).

Table 1: Synopsis of agreement on the principals regarding the prevention and management of workplace violence

Section	Mean rating
Section 1: The role of the trainer as professional	
Trainers should only provide training within their scope of competence	9.2
Trainers should demonstrate their commitment to continuing professional development	9.5
Trainers should act in a professional and ethical manner	4.09
Section 2: Training Content	
Training should be located in the context of a professional relationship	13.05
Training provided should be safe, evidence based and best practice	6.3
Training provided should be needs assessed service specific and fit for purpose	9.8
Training should be conducive with prevailing legal and ethical guidance	6.0
Training should emphasise the primacy of prevention at all levels	8.2

Section 3: The provision of training	
Trainers should strive to integrate training into a broader organisational agenda	12.7
Training should be conducted with due care to the safety of participants	5.4
Training should be conducted in a manner that recognises diversity in all its forms	7.4
Training should be conducted in a manner that respects the dignity of participants	5.3

The suggestion that the Training provided should be needs assessed, service specific and fit for purpose. (Mean rating 9.8.) only just reached 90% agreement, which is again surprising. Delivering training which was not based on needs assessment, was not service specific and was not fit for purpose' would clearly be of concern. It appears however that such practice may still continue or at least that such practice is endorsed by an albeit very small minority of training professionals.

The suggestion that trainers should not practice outside their sphere of competence generated a number of written comment. Participants noted that *"working outside sphere of competence"* would involve *"dangerous practice"* and could *"compromise people"*. Another respondent however suggested *"conflict handling its relational so its everywhere"*.

A number of participants questioned what was meant in relation to one or several of the statements in the charter. A few made specific reference to the charter statement that the trainer should act in a professional and ethical manner suggesting that further clarification of what this meant in practice was required.

"What is competent, professional, ethical?"
"Professional and ethical needs explanation. Professional how do we define and standardize terms. Ethical which point of view/philosophy"
"Professional, ethical". Specify what is meant, what do we want specifically"

This suggests that clarification of what is meant by the ethics of the trainer is required
The National Staff Development and Training Association in North America Code of Ethics identifies six core values and principles of a human service training and development professional irrespective of the specific focus of training (Curry et al 2004).)

1. Beneficence and Non-maleficence
2. Learning, Development, Self-Awareness, and Self-Actualization
3. Human Service Leadership
4. Individual Uniqueness, Cultural Diversity and Competence
5. Self-Determination
6. Integrity

A number of these themes are however already reflected in the charter headings under CPD, Diversity and some existing elements may be argued to represent behaviour which represents integrity in the trainer such as ensuring that training is need assessed, embedded within an organizational strategy embedded within a professional relationship, etc.

Omissions

It was suggested that the charter should contain an obligation that *"trainers evaluate their training"*. Whilst how this was to be resourced or accomplished in terms of what would represent an acceptable quality of evaluation was not specified (and there are suggestions that trainers should not evaluate their own training) the principle seems laudable and will be added to the revised charter for the next round.

It was also noted that the charter makes no reference to the question of *"pain compliance"* and comments suggested that the question should be at least in *"discussion at ENTMA"* within a broader discussion regarding the *"Safety of techniques"*.

The charter makes no explicit reference to trauma and this on reflection appears a potential omission for a number of reasons. Respondents suggested that *"Service user/survival involvement"* must be addressed within the standards and this introduces the need to discuss trauma. Research (Sellers, and Hunter 2005) suggests histories of high levels of assault and abuse in human services students and graduates particularly women who may form the majority of the workforce in many settings where training in the prevention and safer management of violence may be delivered. Evidence suggests (Zarola and Leather 2006) and this research confirms however that the majority of trainers in the industry especially where physical intervention i.e. restraint is taught are male Given the perpetrator of abuse against women is most often male the potential for retraumatisation during training is evident and may be increased in training experiences such as requesting female course participants to restrain a man (Tjeltveit and Gottlieb 2010). The issue of trauma may thus need to be made more explicit.

Irrespective of content a number of respondents observed the fundamental question was *"who would regulate"* a voluntary code of practice was welcomed *"as a start"* but a *"code of conduct for trainers was needed"* that could actually be enforced but the question remains who *"will certify that trainers are professional"*

Conclusion

Trainers providing training in the prevention and safer management of workplace violence face a number of ethical dilemmas. They can face challenges regarding their framing of the problem and thus the nature of the solution they advocate where these do not resonate with the organization concerned. Even if broad agreement on the philosophical approach is reached the financial and human resources necessary to realize that approach may be limited forcing compromises (Paterson 2010). In responding to such challenges trainers need to seek *"to understand their own worldviews and frameworks that consciously or unconsciously may influence their own approach to training."* (Bowie in press) Informed by such an awareness they then need to make use of charters, guidelines and relevant professional codes of ethics as well as decision-making models to guide them in their practice and the choices that inform it (Bergenhenegouwenm 1996, Bowie in press).

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Chapter 2 - Verbal aggression/ violence

A national study on violence against nurses in Lebanon: Prevalence, consequences and associated factors

Paper

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Focus: Research

Abstract

Background and context

Health care settings are notorious for exposing their employees to high levels of violence; both verbal abuse (VA) and physical violence (PV). Literature reports that nurses are disproportionally exposed to violence in healthcare settings. Such an exposure precipitates serious physical, psychological and professional consequences on nurses. Within the Lebanese context, a recent study examining health workers exposure to violence at emergency departments revealed an alarmingly high rate of health workers exposure to occupational violence; particularly nurses.

Methodology

A cross sectional design was utilized to survey a nationally representative sample of nurses registered with the Order of Lebanese Nurses. Stratified random sampling by governorate was utilized. A total of 915 nurses were mailed out the survey questionnaire. Responses were received by registered mail. The survey instrument included four sections collecting demographic/professional information, exposure to violence, job satisfaction (McCloskey Mueller Satisfaction Scale) and degree of burnout (Maslach Burnout Inventory) with a 12 months recall period. Descriptive statistics were used to estimate prevalence of violence. Logistic regression modelling was utilized to determine factors associated with VA and PV.

Findings

A total of 593 nurses returned the questionnaires (response rate of 64.8%). Over the last twelve months, prevalence of nurses exposure to VA and PV were 62%, (CI: 58-65%) and 10%, (CI: 8-13%); respectively. In the study sample 31.7% of nurses indicated likelihood to quit their jobs and 22.3% were undetermined. In terms of burnout levels, 54.1% reported high levels of emotional exhaustion (EE), 28.8% reported high levels of depersonalization (DP) and 24.1% reported low levels of personal accomplishment (PA).

Regression analyses revealed that, compared to nurses with no exposure to VA, nurses reporting exposure to ten or more incidents of VA per year had high levels of EE (OR:6.4; CI:1.76-23.32); high levels of DP (OR:6.8; CI: 3-15); intention to quit job (OR:3.9; CI: 1.8-8.3) and reported absence of anti-violence policies (OR:3; CI: 1.5-6.3). Nurses that were ever exposed to PV were more likely to be males (OR: 2.2; CI: 1.1-4.3), working extended day/night shifts (OR: 2.8; CI: 1.4-5.5) and subject to ten or more incidents of VA per year (OR: 46.7; CI: 10.1-214).

Implications

An alarming two-thirds of respondents reported exposure to VA, which suggests that it has become a tolerated aspect of the work environment. Exposure to PV, although relatively low (10%) is disconcerting due to the severe negative consequences of such exposures. The findings of this study demonstrate that exposure to VA is a significant predictor of the three subscales of burnout, intention to quit and exposure to PV. Furthermore, nurses reported presence of anti-violence policies and regulations in the institution played a protective role against exposure to PV.

Being the first national study in the Arab world to investigate nurses exposure to violence, this study provides evidence on which policy and decision makers could base their decisions and interventions for the protection of nurses from violence and the creation of work environments conducive to productivity and retention.

Learning objectives

1. Nurses› exposure to verbal Abuse at healthcare settings precipitates serious negative consequences on the nurses and the hospitals; including: increased intention to quit and burnout.
2. The absence of anti violence policies at healthcare institutions is significantly associated with nurses› increased exposure to violence.

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Patterns and consequences of healthcare violence in the Philippines: A qualitative investigation

Paper

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Focus: Practice

Abstract

Healthcare workers are at high-risk for being targets of workplace violence. This violence is occurring four times more often in healthcare settings than in all of private industry combined (NIOSH, 2002). The negative effects of workplace violence included minor and serious physical injuries, temporary and permanent physical disability, psychological trauma, and death (McKinnon & Cross, 2008). Most nurses in Philippine hospitals have experienced certain degree of violence (Babate, 2010). The negative effects of violence were demonstrated by fear, decreased morale, worker absenteeism, turnover, and loss of productivity.

Interviews were done over a 10 month period (between February and November 2011) with 12 nurses working in hospitals (classified as primary to tertiary settings) in Southern Philippines. Observations were conducted and institutional document reviews were done.

The findings indicate that violence was primarily perpetrated by psychiatric patients (physical) and physicians (verbal). Participants reported the following consequences: worker stress and injury, patients being restrained, parental eviction from the emergency room, delays in patient care, and perceived negative image of the medical center by parents and visitors.

The study recommended that interventions would be introduced such as workplace violence prevention training; conduct workplace violence audit; develop new guidelines; and improved institutional governance .

As this is the first known study in this part of the country, this study is significant because it investigated a problem of importance to governmental entities, the professional community, and professional organizations in the Philippines. The data from this study may be used to guide further research in the field. Further, data from this study can also be used to develop interventions appropriate to reducing the negative effects of violence for healthcare employees.

Learning objectives

Using workplace violence model as the conceptual framework of this study, the study attempts to describe the context of workplace violence in healthcare settings in the Philippines including its consequences for workers, perpetrators of violence, patients, and the healthcare employer; and recommends potential interventions to reduce the incidence and negative consequences of healthcare workplace violence.

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Violence in the health sector in Nepal: A retrospective analysis of five years data

Paper

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Focus: Organisational
Keywords: Health professional protection act, health set-up, misbehavior, physical assault, violence

Abstract

Introduction

Nepal Medical Association (NMA) is the professional organization of medical doctors in Nepal and was established on 4 March, 1951. NMA, with its clear vision and goals, has been actively working for professional rights, medical ethics, advocacy and improvement of health services since its establishment. Nepalese doctors and the health institutions have been facing difficult and unpleasant situations. The morale of the doctors and their health service teams has been degraded because of the growing number of attacks they have been encountering. NMA is concerned about the long term impact of such attacks on the whole health set-up of the country. Incidents of intentional damage to hospital infrastructure, vehicles, misbehavior and physical assaults against doctors as well as kidnapping of health personnel are on the rise in Nepal. NMA has been trying to draw the attention of the concerned authorities about the trend of rising violence against the health-care providers and to the overall negative impact to the health service.

Methods

NMA registers all incidence of violence against health personnel and health set-up. Victims of violence request NMA to raise voice for professional right and safety. The data of such incidents registered at NMA from January 2007 to January 2012 was analyzed for this study. The incidents were recorded in the form of infrastructure damage of the hospitals, physical assaults and misbehavavior against health personnel, damage to vehicles, kidnapping of health personnel and so on. We analyzed the data of the incidents reported to NMA.

Results

The total number of incidents of violence recorded at NMA from 2007 January to 2012 January was 61. Of these 61 incidents, 'verbal' violence against the health personnel was the highest with 27 incidents (44.26%, CI: 31.55% – 57.55%) followed by physical assault against health personnel with 11 incidents (18.03%, CI: 9.36% - 29.98%). Similarly, infrastructure damage of hospitals was the third most common incident with 8 incidents (13.12%, CI: 5.83% - 24.22%). Likewise, damage to vehicles, kidnapping of health personnel and others incidents were at 3 (4.92 %, CI: 1.03% - 13.70%), 3 (4.92 % CI: 1.03% - 13.70%) and 9 (14.75 %, CI: 6.97% - 26.17%) respectively. Most of the incidents 21 (65.63%, CI: 46.80% - 81.43%), were at the emergency department. Male health professionals were mostly victimized and the perpetrators were mostly the relatives of the patients none of whom were penalized.

Conclusions

In this study, misbehavior with health personnel was seen most frequently followed by physical assault and infrastructure damage. Such incidents not only hamper proper health care delivery but also deprive the patients from much needed services. Nepal is passing through a very difficult phase of political instability and uncertainty and increasing violence against the health professionals and health institution is a reflection of these chaotic times. The NMA follows international humanitarian law, human rights and medical ethics. So, we are raising our voice to have the health professional protection act implemented so that the health professionals can continue to serve the public without fear of intimidation, violence and personal safety.

Introduction

The Nepal Medical Association is a professional organization of medical doctors in Nepal and was established on 4 March, 1951. The Association, with its clear vision and goals, has been actively working for professional rights, medical ethics, advocacy and improvement of health services since its establishment.[1] As a professional organization it raises voice against any violence in health personnel and institute. Association takes action in the form of emergency executive meetings, press release, press conference, delegation to concerned authority of Nepal Government for professional safety.

However, Nepali doctors and the health institutions have been facing difficult times recently. The morale of the doctors and their health service teams has been degraded because of the growing number of attacks they have been facing. The association is greatly concerned about the long term negative impact of such attacks on the

health service. Now-a-days, incidents of intentional damage of hospital infrastructure, verbal abuse and physical assault against health personnel, damage to vehicles which belongs to health personnel and hospitals and even cases of kidnapping of health service providers are increasing in Nepal.

Such violence in health facilities and against health professionals should be protected by law. The association has thus been drawing the attention of the Government of Nepal for the formulation and implementation of the health professional protection act.

Methods

Generally, victims of violence in the health set-ups come to our association to raise their voice for professional rights and safety. These incidents are recorded in the incident registry of the NMA. Data from this registry from January 2007 to January 2012 was analyzed for this study. The incidents are recorded in the form of infrastructure damage of hospital, physical assault (raising fists, slap, kick, punch, etc.) against health personnel (doctors, paramedics, nurses, etc.), misbehavior (verbal abuse/threats) against health personnel, damage to vehicles (of health personnel and hospital vehicles and ambulance), kidnapping of health personnel, and so on. We analyzed this data as well as that of some incidents published by national daily newspapers. We tried to find out where the incidents occurred – outpatient, inpatient, or emergency Department. Similarly, the natures of violence, like verbal abuse, misbehavior or physical assault was studied. Damage of the property of the health institutes and kidnapping and others (Bomb-blast targeting to health institutions and professionals, violence against the media for reporting health set-ups incidents, monetary demands) were analyzed. We also tried to study the compensation given to health institutions as well as to the patient's party and the penalty given to the culprit of violence.

All those incidents of the five year period registered in NMA for which the association had taken action in the form of emergency executive meetings, press releases, press conferences, and delegations to the concerned authority of the Nepal Government have been included in this study. All the data has been analyzed using the statistical software STATA 9.0. Descriptive statistical measures such as mean, standard deviation and proportion of incident with 95 % confidence interval (C.I.) have been reported.

Results

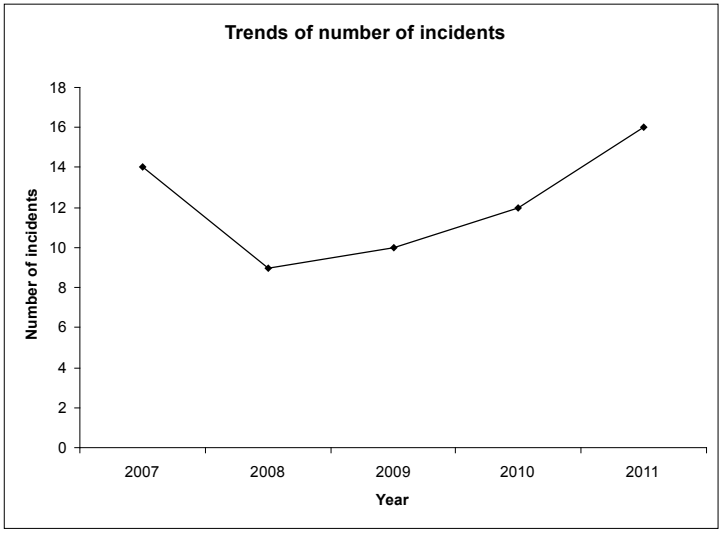
The total number of violent incidents recorded at NMA from 2007 January to 2012 January was 61. Among these 61 incidents against the health set-ups, misbehave against health personnel was the highest at 27 (44.26 %, CI: 31.55 % - 57.55 %) followed by physical assaults against health personnel at 11 (18.03 %, CI: 9.36 % - 29.98 %). Similarly, infrastructure damage of the hospitals was the third most common incident which was at 8 (13.12 %, CI: 5.83 % - 24.22 %). Likewise, damage to vehicles, kidnapping of the health personnel and others were at 3 (4.92 %, CI: 1.03 % - 13.70 %), 3 (4.92 % CI: 1.03 % - 13.70 %) and 9 (14.75 %, CI: 6.97% - 26.17 %) respectively.

Table1. Total number of violent incidents over the five-year period of January 2007 to January 2012

S.N.	Incidents	Number of incidents	Percentage
1	Misbehavior against health personnel	27	44.26 %
2	Physical assault against health personnel	11	18.03 %
3	Infrastructure damage of hospital	8	13.12 %
4	Damage to vehicles	3	4.92 %
5	Kidnapping of health personnel	3	4.92 %
6	Others	9	14.75 %
Total		61	100.00 %

In this study, we analyzed the data according to the number of incidents per year. Among the total incidents the highest recorded was 16 (26.23 %, CI: 15.79 % - 39.07 %) in 2011 and lowest was 9 (14.75 %, CI: 6.97 % - 26.17 %) in 2008. Similarly, the recorded number of incidents was 14 (22.95 %, CI: 13.15 % - 35.50 %) 10(16.39 %, CI: 8.15 % - 28.09 %) and 12(16.67 %, CI: 10.60 % - 31.84 %) respectively for the years of 2007, 2009 and 2010. The average number of incidents per year has been reported as 12.2(SD; ± 2.86).

Figure1. The trends of the number of incidents per year



Most of the incidents of physical assaults and misbehave were against male health professionals. Physical assaults, misbehave and infrastructure damage were more common in the public sector 22 (64.71 %, CI: 46.49% - 80.25%) than in the private 12 (35.29 %, CI: 19.75% - 53.51%). Similarly, these incidents happened more in emergency departments than in other departments. The number of incidents recorded in the emergency departments was 21 (65.63 %, CI: 46.80% - 81.43%) , in the OPD/IPD was 7 (21.88 %, CI: 9.28% - 39.97%) and in other departments was 4 (12.50 %, CI: 3.51% - 28.99%). And the reasons for the incidents were the patients' dissatisfaction of services, death of patients in the treatment process, lack of health infrastructure as well as overcrowding. In these incidents, the perpetrators were mostly the relatives of the patients but other groups of youngsters were also involved in the violence. None of the perpetrators of the violence in these incidents in health set-ups were legally penalized for their actions.

Discussion

Health care professionals all over the world are facing more harsh behavior than ever before.[2] In this study, among these incidents in health set-ups, misbehave against health personnel was the highest at 27 (44.26 %) followed by physical assault against health personnel at 11 (18.03 %), which is similar to other studies.[3,4,5] Infrastructure damage of hospitals and damage to vehicles were seen as the third and fourth common incidents which may be due to inability to cope with the death of their near and dear one, not understanding the gravity of illness and treatment that was given to the patient and illiteracy. In this study, the majority of the health professionals victimized were male rather than female, due to the our cultural reasons and social behavior.[6] In one study a noticeable trend of a rising number of assaults against nurses has been described.[7]

In this study, most of the incidents of physical assaults, misbehave and infrastructure damage were noticed in the emergency departments at 21 (65.3%) than in other departments which is similar to other studies.[8,9,10,11,12] Most of these incidents occurred in public institutions at 22 (64.71%) than in private at 12 (35.29%) which is similar to other studies.[13,14] Majority of the people attend public health institutions which is cheaper than private for services. So, a chance of violence in health set-ups is higher in public institutions. The reasons for the incidents were the patients' dissatisfaction of services, death of patients in the treatment process, lack of health infrastructure as well as overcrowding. The perpetrators were mostly the relatives of the patients and their companions, which has also been described in a number of studies.

Nepal is passing through a very difficult phase of political instability and uncertainty as a result of the recent decade-long insurgency.[1] To perform our respective duties efficiently, honestly and sincerely in such an atmosphere of aggression, insecurity and rampant political situation violence is becoming more difficult day by day. Violence in all forms has been a major threat to health security.[15] A secure working environment is a prerequisite for the delivery of effective healthcare.[16,17,18,19,20] So, a feeling of insecurity of the health personnel is one of the biggest, most immediate, and yet unrecognized humanitarian problems in today's conflicts.[21,22] In this study, there were three cases of kidnapping of health personnel but no death was recorded in health set-up violence. In some reports even death of medical staff and physicians has been described.[23,24]

In this study, even cases of damage to vehicles carrying health personnel and to ambulance were seen. Similar cases of damage to ambulances carrying patients were described in Libya and Afaghanistan.[17]

Therefore, The Nepal Medical Association has proposed that the Government of Nepal to implement the health professional protection act and create legal standards for the protection of health professionals and institutions. Only if the government of Nepal implements the health professional protection act and creates a secure working environment can the medical personnel provide effective health care to the people. In this study, none of the culprits responsible for the violence in the health set-ups was legally penalized. This is may be due to the current political instability and the weak law and order situation of the country. But in other countries penalties have been handed to the perpetrators.[3]

In this study, cases of violence in health set-ups are seen to be increasing. So, the quality of patient care may also compromise day to day. Other studies also shown that violence may have significant implications for the quality of patient care provided.[25,26]

Conclusions

Attacks against health professionals and health facilities have become a feature of the modern era in developing countries. And increasing trends of violence in the health set-ups has been documented in Nepal during the past five years.

The medical community has a responsibility to speak out collectively to protect health professionals in fulfillment of their ethical duties to the people in their care without the risk of arrest or attack or intimidation. NMA follows international humanitarian law, human rights and medical ethics. So we are raising our voice to implement the health professional protection act for effective health care delivery. Health security is the first line of defense against the disruption of health care system. As globalization brings more complexities, dealing with the increased scale and extent of health security will require greater international efforts and political support.

Limitations

This is a descriptive analysis of the data which was recorded by the Nepal Medical Association over the five year period. All incidents of violence against health personnel and health institutions in Nepal over the five year period have certainly not been registered at the NMA. So, a larger study is necessary to appreciate the increasing trend of violence against the health sector.

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Picture1. Protest against the perpetrators by the health professionals in Kanti Children Hospital Kathmandu, Nepal .11 September 2011

Picture 2. Infrastructure damage of health set-up by perpetrators

Picture 3. A protest rally organized by health professionals in Tribhuvan University Teaching Hospital, Kathmandu Nepal. 31 March 2010

Learning objectives

1. Violence in health facilities and professionals is increasing in Nepal.
2. Health professionals and facilities to be protected by the special law.
3. Government is to be made accountable for it.

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Types and impact of violence against nurses in a non psychiatric/mental hospital in Nigeria

Poster

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Focus: Practice

Introduction

Violence against nurses is an internationally growing problem affecting nurses' satisfaction and productivity. This is because violence between nurses and patients weakens the therapeutic relation between them and violence among nurses affects co-worker relationship ultimately affecting health service delivery adversely. All acts of aggression, physical assault, sabotage or threatening behavior that occurs in a work setting and causes physical or emotional harm to patients, coworkers, or managers are considered as workplace violence. According to World Health Organization (WHO) (2002), workplace violence is defined 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. The description above suggests that the scope of violence at workplace is wide. Occupational Safety Health and Administration (OSHA) in Grayson (2010) divided workplace violence into four categories namely, an employee involved with a criminal outsider (e.g. robbery), an employee involved with a client (e.g. customer, student, patient), an employee involved with a co-worker and importantly fourth category an employee involved with a spouse or other significant relationship. He further stated that among these categories, Type-3 violence (worker vs. co-worker) gets the most attention probably because their relationship affects the general working environment and is most often identified and confused with the broader topic. It is also suggested that in a tight economy, casualties from all four categories are likely to increase.

In developed countries, the prevalence of workplace violence is high. Assaults and threats of violence number almost 2 million a year (most common was simple assaults: 1.5million a year and aggravated assaults: 396,000, Rapes and sexual assaults: 51,000). These resulted to such economic impact of 500,000 employee's 1,175,100 lost work days each year, • $55 million lost wages annually, lost productivity, legal expenses, property damage, diminished public image, increased security. In a study on workplace violence nature, impact, and preparedness by Lo, Chappell, Kwok and Wu (2011), using 1,198 organizations, it was discovered that some respondents reported that they had experienced violence over the 2 years preceding the study.

In both the private and government sectors, nonphysical violence happened more frequently than physical violence as in the study of Worker-on- worker violence among hospital employees by Arnetz, Aranyos, Agar and Upfal (2011),of which the majority of the sampled (87%) of worker-on-worker incidents involved non physical conflicts. Respondents believed that workplace violence caused the loss of key employees and clients. In a related study on Workplace violence in nursing today by Araujo (2011), it was revealed that majority of workplace violence is non physical, leaving no scars. However, for nurses, the emotional damage to the individual affected productivity, increase medication errors, incur absenteeism, and decrease morale and overall satisfaction within the nursing profession. This results in staffing turnover and creates a hostile work environment that affects the culture within the organization. Another study by, Gate, Gillespie, Succop. Santer and Farra (2011),using a cross-sectional design examined how violence from patients and visitors is related to emergency department (ED) nurses› work productivity and symptoms of post-traumatic stress disorder (PTSD) revealed that ED nurses experience a high prevalence of physical assaults from patients and visitors. Ninety-four percent of nurses experienced at least one posttraumatic stress disorder symptom after a violent event, with 17% having scores high enough to be considered probable for PTSD. In addition, there were significant indirect relationships between stress symptoms and work productivity.

In Nigeria, like most developing countries, violence is under reported and in the face of unequal access to health, health care professionals may leave the industry because of the threat of violence, leading to a further reduction in health services available to the general population and an increase in health costs. Considering the fact that empirical report which form the basis for all intervention in the area of workplace violence is grossly lacking in Nigeria, the present study therefore seek to describe the types and impact of violence against nurses in non psychiatric\non mental institution.

Methods

Research design: Cross sectional descriptive was adopted for the study.
Study sample: The study is based on data collected from nurses working in a teaching hospital in Ebonyi State of Nigeria. A sample of one hundred and forty (140) nurses was drawn from the total population.

Study instrument: A self administered questionnaire which consisted of two sections was used for the study. The first section assessed the bio- occupational data while the second section assessed types and impact of violence on six impact variables of frustration, insecurity, heightened anxiety, reduced job satisfaction, decreased

morale and productivity. It also considered the causes of violence as perceived by the respondents. Ethical issue: Ethical approval was gotten from the institution and permission gotten from all respondents.

Data analysis: All the data collected were analyzed using frequencies and percentages.

Results

Table 1 above shows the demographic and occupational characteristics of the respondents. Females account for the majority of the respondents representing 80% (112) of the total respondents. Respondents in the age bracket of 18 – 28years are in the majority accounting for 42% (59) and 14% (20) represent the least (49 – 60).

Table 1: Demographic and occupational characteristics of the respondents (n = 140)

Variables		Frequency	Percent
Sex	Female	112	80
	Male	28	20
Age	18 – 28	59	42
	29 -38	33	24
	39 – 48	28	20
	49 – 60	20	14
Cadre	Registered Nurse	52	37
	Senior Nursing Officer	21	15
	Principal Nursing Officer	26	19
	Assistant Chief Nursing Officer	27	19
	Chief Nursing Officer	11	8
	Deputy Director Nursing Services	3	2

The respondents range from 18 to 60years and cut across several categories of staff from the Registered Nurse (RN), Senior Nursing Officer (SNO), Principal Nursing Officer (PNO), Assistant Chief Nursing Officer (ACNO), Chief Nursing Officer (CNO) to the Deputy Director Nursing Services (DDNS). 37% (52) represent the majority made up of the Registered Nurses whereas the DDNS is in the least accounting for 2% (3) of the total correspondents.

Table 2: Frequencies of aggressive incidents

Variables	Frequency	Percent
Physical (1%)	1	0.71
Non-Physical (72%)		
Aggression	78	55.71
Intense verbal abuse	23	16.43
None (27%)	38	27.14

Violence experienced in the institution is broadly categorized into two, physical and non-physical. Physical violence accounts for 0.71% (1) and Non physical violence represents 72% of the recorded incidents out of which aggression accounts for 55.71% (78) and intense verbal abuse 16.43% (23) respectively. Therefore, out of 102 respondents that experienced violence, more than 99% suffered non physical violence and less than 1% encountered physical violence respectively.

Table 3: Impact of aggression (n = 102)

Impact Variables	Frequency	Percent
Frustration	43	25
Insecurity	14	8
Heightened anxiety	22	13
Reduced Job Satisfaction	31	18
Decreased Morale	45	26
Productivity	18	10

Violence has impacted negatively on the psyche of nurses and this has manifested in a number of ways. Decreased morale accounted for the highest outcome representing 26% (45) and productivity suffered the least accounting for 10% (18). Others include reduced job satisfaction 18% (31), heightened anxiety 13% (22), insecurity 8% (14) and frustration 25% (43).

Table 4: Causes of violence against nurses (n = 102)

Persons	Variables	Frequency	Percent
Nurses (62%)	Poor interpersonal relationship	11	18
	Duty schedule	57	91
	Job allocation	7	11
Patients (11%)	Poor interpersonal relationship	10	90
	Lack of communication	10	90
	Delayed treatment	4	38
	Missed opportunity	7	62

A number of factors has been identified as causes of violence in the institution. Nurses' role is strongly implicated as a major cause of violence accounting for 62% and patients 11% of the causes of violence in the institution. This also means that nurses against nurses' account for 85% while client against nurses account for 15% of all the incidents as a whole.

Among the nurses role, problems associated with duty schedule accounts for 91% (57) and others including interpersonal relationship 18% (11) and job allocation 11% (7). Smilarly, patients' poor interpersonal relationship and lack of communication accounts for 90%, missed opportunity 62% (7) and delayed treatment 38% (4) of all the total violence caused by patients.

Discussion

The aim of the study was to determine the types and impact of violence against nurses. Non physical violence was found to be the frequently experienced. It accounts for approximately 99% of all the incidents and it is good to note that co-nurses generated causes is a major factor whereas, physical violence was responsible for only about 1%. This finding was similar to studies carried out by Lo, Chappell, Kwok and Wu (2011), Arnetz, Aranyos, Agar and Upfal (2011), and Araujo (2011). In these studies, non physical violence was significantly the predominant type of workplace violence. In contrast, the study conducted by Gate, Gillespie, Succop. Santer and Farra (2011), reported a high prevalence of physical assaults against nurses from patients and visitors. However, this is not surprising because the sample was predominantly ED nurses who usually encounter patients and relatives that are under emotional tension.

The impact of violence against nurses was measured on six impact variables of frustration, insecurity, heightened anxiety, reduced job satisfaction, decreased morale and productivity. It was discovered that violence against nurses led to the experience of all the impact variables. The whole variables when matched with demographic and occupational characteristics of the respondents, shows that junior nurses are more vulnerable to violence. This finding is in agreement with most studies in the area of impact of workplace violence on nurses and other health workers. For instance Araujo (2011), reported that the emotional damage of violence affected productivity, increase medication errors, incur absenteeism, and decrease morale and overall satisfaction within the nursing profession. Similarly, study conducted by, Gate, Gillespie, Succop. Santer and Farra (2011), revealed that among nurses who experienced violence, ninety-four percent developed at least one posttraumatic stress disorder symptom, 17% having scores high enough to be considered probable for PTSD. In addition, there were significant indirect relationships between stress symptoms and work productivity.

Conclusion and recommendation

Violence against nurses in a Nigerian health institution is high and fellow nurses are mostly responsible. Violence has serious consequences for the nurses and patients. It is recommended that institutional and departmental administrators should collaborate with nurses to develop and implement preventive strategies to reduce and manage violence, paying attention to those predominantly happening in their peculiar environment.

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Learning objectives

Participants will:
1. show understanding of the common type of violence predominant in non psychiatric/mental institutions in Nigeria.
2. appreciate the impact of violence in non psychiatric/mental institutions in Nigeria.

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Violence against physicians in Mansoura University Emergency Hospital, Egypt

Paper

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Focus: Research

Abstract

Background

The objectives are to estimate the prevalence of different types of violence against physicians working in the emergency hospital, its associated factors, circumstances of violence, type of perpetrators, and victims' response.

Methods

This cross-sectional descriptive study was carried out in Emergency Hospital of Mansoura University, Egypt during the first half of January 2012. The data were collected through the adapted version of a self-administered questionnaire developed by the International Labor Office/International Council of Nurses/World Health Organization/Public Services International on workplace violence in the health sector. Out of 73 questionnaires distributed, 68 (93.2%) were returned.

Findings

Only 7.4% of physicians were not exposed to any violence during the past year. The period prevalence of physical, verbal, bullying and sexual violence are 60.3%, 76.5%, 58.8% and 30.9%; respectively. Doctors of younger age and shorter duration of work are at higher risk of both physical and verbal violence. Males are at higher risk of bullying while females are more exposed to sexual harassment. The majority of violent events occurred inside the hospital. Patient's relatives/visitors are the most frequent perpetrator of physical, verbal and bullying violence. While colleagues were the most frequent perpetrator of sexual harassment. The victim's response varies from one type of violence to another. There is no hospital policy for safety against any type of violence, no reporting system and no support to the victims.

Conclusion

Doctors working in emergency hospital experienced a higher level of different types of violence. There is an urgent need to formulate and implement a policy for dealing with violent events.

Learning objectives

1. Physicians are exposed to high level of all types of violence in Emergency hospitals.
2. There is a lack of policy for violence prevention and control.

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Patients violence/aggression towards hospital staff in South-East Asia: A systematic review

Paper

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Focus: Research
Keywords: South-East Asia, patient's violence/aggression, hospital staff

Abstract

South-East Asia is a region with a population of approximately 600 million. Though most are developing countries, its health care sectors had been developed in according to the western standard and hospitals in many countries become medical hubs serving people from other regions. High demand for health care services lead to high risks for hospital staff to violence and/or aggression both horizontally/laterally or hierarchically. However, there are very few evidences and low awareness of violence of hospital staff in this region. Therefore, this systematic review had been conducted to answer these below questions: What is the pattern/prevalence of violence/ aggression towards hospital staff in this region? What is the impact of violence /aggression towards hospital staff? What are the interventions which had been initiated? Does it work? Can it generalize to the whole region? Can this review be used to move the issue forward?

The electronic searches had been conducted on the databases: SCOPUS, EBSCO host, HW Wilson, OVRC, Emerald, OCLC, Wiley online, Blackwell synergy, Pubmed, Proquest, Mosby's Nursing consult, CINAHL and BMJ Journals. The keywords which had been used: Violence / Aggression, Workplace Violence, patient's violence and hospital staff and names of 11 countries in the region: Brunei, Cambodia, East Timor, Indonesia, Laos, Malaysia, Myanmar, Philippines, Singapore, Thailand and Vietnam. Searches had been limited to publications between year 2000 to 2012 and in English language.

Since only studies took place in the determined countries were included only two articles fitted to the criteria.

In terms of pattern / prevalence of violence / aggression towards hospital staff in the region, Abdullah et al (2000) found that nurses working in the Emergency Department in a hospital in Singapore had been verbally abused 74.3% and physically assaulted 5.7% in the past 3 months. Kamchuchat et al (2008) found that nursing staff in a general hospital in the South of Thailand had been verbally abused 38.9%, physically abused 3.1%, sexually abused 0.7% and more than one type abused 38.9% in the past year. However, nurses with younger age and working in high risk units such as emergency and out-patient departments had higher risks. Most of the perpetrators were patients and their relatives.

In terms of effect / impact of violence, the study in Singapore found that 94% of these nurses had psychological effect and 60% had physiological effect. The Thai study mentioned the psychological impact such as distress, anger though no percentage had been reported. However, nurses facing with verbal abuse, 50% loss good relationship with coworkers and 5% reduced relationship with family members. For the coping mechanisms, both studies showed similar results, most nurses facing with violence may discuss, report and keep quite as a way to cope with the problems. These 2 studies also noted that trainings are most needed by nurses to handle with aggression. However, both studies pointed to the lack of supporting system for nurses in dealing with violence in the workplace.

This systematic review demonstrated lack of awareness and initiatives in prevention of violence on nurses or other health care staff in South-east Asia. These is an urgent need for Professional Association to activate an awareness and initiatives of violence prevention in the workplace since it had a high impact to working life of hospital staff and will effect quality of care at last.

Background

Patient violence and aggression towards health care staff is a common problem and has long been reported, particularly in the Psychiatric Department (Nolan, et. al. 1999). Nurses are more likely to be victims of patient violence and aggression because they take responsibilities for care 24 hours. (McGuire & Ryan, 2007) Exposure to these violence and aggression affect staff both physically and psychologically, as well as an impact to quality of care. Physical injuries due to such violence/aggression have been reported ranging from 2% to 16% (Noble & Rodger, 1989; Carmel & Hunter, 1993). A systematic review noted that psychological effect which may take several months or years to recover ranged from : shock, depression, demoralization, upset, loss, grief, guilt& PTSD etc. (Lim, 2011) In addition, these violence /aggression can also affect relationships of such persons to their family members or they may use negative coping strategies which reduce quality of care consequentially (Needham et al, 2005) However, most of these evidences came from developed countries and rarely from developing countries despite they may face with similar problems.

South-east Asia is a region which approximately 600 millions population. Hospital care in this region is not only provided services to its people but also to people from other regions through medical hub which is a main industry of the region. Hospital staff in the region, therefore, are in risk of patient violence/aggression due to their high demand and expectation. Nevertheless, awareness and prevention of these phenomena are still very little. In order to identify evidence of patient violence/aggression towards health care staff this study aimed to identify prevalence of patient violence/aggression towards hospital staff in this region.

Methods

An electronic search from databases included SCOPUS, EBSCO host, HW Wilson, OVRC, Emerald, OCLC, Wiley online, Blackwell synergy, Pubmed, Proquest, Mosby's Nursing consult, CINAHL and BMJ Journals was conducted. Inclusion criteria was (1) Articles in English (2) Articles published from January 2000 to February 2012 (3) Articles which data were collected in countries included: Brunei, Cambodia, East Timor, Indonesia, Laos, Malaysia, Myanmar, Philippines, Singapore, Thailand and Vietnam. Key words in search strategies included violence and patient, aggression and patient, work place violence and hospital, violence and nurse & violence and doctors & violence and hospital staff. Titles and abstracts were screened for inclusion criteria. The full text articles were retrieved if its titles and abstracts containing some key words. However, since it is a rare study in the regions, only 2 studies fitted the criteria and relevance for reviews.

Results

Two studies related to patient violence/aggression in Southeast Asia were conducted in Thailand and Singapore and focused on nurses. An electronic search could not find articles on violence inflicted to other health care staff. Data were summarized in Table 1. Bin Abdullah et al (2000) identified violence/aggression towards nurses in Emergence Department in a hospital in Singapore by using questionnaire. Incidence of violence for the past 3 months was 5.7% physically and 74.3% verbally. Perpetrators in this study were patients and their realties. Effects from violence phenomena were measured as physiological and psychological effects. Ninety four percent had psychological effects such as anger/irritability. Sixty percent had physiological effects such as headache, muscle tension and loss/increase appetite. More than half also reported of feeling unsafe. Main coping mechanisms were discussed with coworkers, reported and kept quiet. Since there is no formal supporting system, respondents showed need for training in aggressive management, personal safety awareness, effective communication, body language and restraint technique

Kamchuchat et al (2008) using survey and key informant interview to 545 nurses of a 500 bed general hospital in Southern Thailand The violence prevalence for the past year was 38.9% for verbal abuse, 3.1% for physical abuse, 0.7% for sexual abuse and 38.9% for multiple abuse. Violence prevalence throughout the whole period of nursing career was higher. Though there is no percentage report of effects, a psychological effect such as distress, anger has been noted. In order to cope with the situation, 73% keep quiet and 69% try to avoid violence situation. Patients and their relatives were the main perpetrators in verbal and physical abuse whereas co-workers were the main perpetrators of sexual abuse. A social impact has been mentioned, 50% felt of loss of good relationship and 5% reduced family relationship. Though there was no formal supporting system, some training on communication skills and safety training was reported by respondents to assist them in reduction of verbal abuse 40%. Logistic regression showed younger age to be a risk factor and working in the front- line or operating room increased the odds of violence. Training need was mentioned by respondents in handling aggression. A security surveillance system was recommended.

Table 1: Summary of studies related to violence/aggression towards health care staff in South-east Asia

Authors	Country	Working Unit	n	Types of violence	Perpetrators	Effects	Formal supporting system
Bin Abdullah et al (2000)	Singapore	Emergency Deportment	35	Physical (57%) and verbal (74.3%)	Mainly by patients and relatives	Physiological and psychological	None
Kamchuchat et al (2008)	Thailand	General hospital (500 beds)	545	Physical (3.1%) Verbal (38.9%) Sexual (0.7%) and multiple(38.9%)	Mainly by patients and relatives	Physiological and social	None

Discussion and recommendation

Though this systematic review found only 2 studies relevant to the title of the study, research findings showed that nurses in South-East Asian countries faced similar prevalence of patient violence/aggression similar to those in developed countries. Though the effect mostly were psychologically (Needham, et al 2005; Lim, 2011) it may have long impact to quality of life of nurses and affect quality of care consequently. This review also pointed that with different social norms and culture between hospital settings in developed and developing countries, nurses face similar problems of work place violence. Moreover, this review also point to an urgent need to find prevalence of patient violence/aggression in other health care staff in this region which may face similar phenomena as nurses. The results of this review also showed that there is no supporting system or an awareness raising for patient violence/ aggression among nursing professionals in this region. Training for

nurses to enhance skills in dealing with violence at some specific units may need to be developed as a model for prevention of patient violence/aggression for the whole hospital, country and region at last.

With only two articles retrieved for the review, the exclusion of articles not in English languages, unpublished documents or those not in the database system may hinder its findings. However, compared to the prior systematic review by Needham et al (2005) and Lim (2011), it can be summarized that studies on patient violence/aggression towards health care staff are very rare in this region. The nursing and other health professional associations in the region should not only support for more studies on this issue but also for formulating policies and intervention programs to prevent violence in the workplace and support staff who had been abused.

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Learning objectives

1. Patient›s violence/aggression on hospital staffs in South-East Asia is high and had a substantial impact to hospital staffs
2. Lack of awareness and initiatives of violence on hospital staffs in South-East Asia have an effect to their working lives and quality of care at last

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Prevalence and correlates of workplace aggression in Australian clinical medical practice

Paper

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Focus: Research

Abstract

Background

There is a limited body of significant published research on the prevalence, predictors or impact of workplace aggression in medical practice, internationally. Most studies have focussed only on patient aggression or specific forms and the few reported Australian studies have mainly focussed on patient aggression in general practice (family medicine). As in many countries, there are no comprehensive, national data sources on the prevalence, prevention or impact of workplace aggression in Australia. Furthermore, workplace aggression is considered to be grossly underreported by health workers. As a consequence, the most reliable data on workplace aggression are likely to be found in the research literature. This provided the impetus for the first nation-wide study of workplace aggression from all sources experienced by all clinical medical practitioner sub-populations in Australia.

Methods

The study was a component of the third wave of the Medicine in Australia: Balancing Employment and Life (MABEL) longitudinal survey, conducted between March 2010 and July 2011. It elicited cross-sectional, self-report data on the frequency of verbal or written and physical aggression experienced in the previous 12 months from patients, patient relatives of carers, co-workers and others external to the workplace. The study also collected information on personal profile and work-related variables, including age, gender, personality and the presence of workplace aggression prevention and minimisation strategies. Descriptive and multivariate analyses identified aggression prevalence and key associates of aggression exposure.

Findings

Overall, 70.6% of clinicians experienced verbal or written aggression and 32.3% experienced physical aggression in the previous 12 months. Consistent with the broader literature, aggression from patients was most prevalent, followed by aggression from patient relatives or carers, co-workers and others external to the workplace. More female clinicians overall, hospital-based clinicians and international medical graduates in general practice experienced workplace aggression. Age and years of experience since graduation were significantly negatively associated with frequency of exposure. Other significant associates were identified, including key work-related factors such as hours of work and the presence of some aggression prevention and minimisation strategies.

Implications

Workplace aggression in clinical medical practice is a significant professional and public health issue. With the aging of the health workforce and the growing reliance on international medical graduates, both in Australia and the rest of the developed world, a failure to address this important occupational health and safety concern may lead to persisting challenges in the recruitment and retention of medical practitioners. This is a critical consideration in an era of increasing shortages of clinicians across the globe. The results of this study provide important baseline data and an impetus for ongoing research. It will also provide an important body of evidence for legislators, policy makers, health services and the medical profession in efforts to more effectively prevent and minimise the extent and impact of workplace aggression in medical practice settings. This may not only ensure a safer environment for clinicians and service users, but may provide a significant contribution to ensuring that rural, regional and metropolitan communities have adequate access to medical care into the future.

Learning objectives

1. Workplace aggression is a common feature of clinical medical practice, and is a significant professional and public health issue.
2. Failure to address this important occupational health and safety concern may contribute to persisting challenges in the recruitment and retention of medical practitioners.

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The Violence in Emergency Nursing and Triage (VENT) Study: Quantitative results

Paper

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Focus: Practice

Background and context

Whilst violence in the healthcare sector is a legitimate concern for all healthcare professionals, it is especially significant for the nursing profession which has been identified as the group most vulnerable to such violence. This paper is a preliminary report of the quantitative results from the VENT Study: a national study of Australian Emergency Department (ED) nurses' experiences with patient-related violence.

Methodology

Part I of the VENT Study involved the distribution of surveys Australia-wide to the 1150 members of The College of Emergency Nursing Australasia (CENA). A survey comprising 75 items was developed using the current literature on the topic and tested on an expert panel of nurses to establish face and content validity. Respondents were given the option of completing a paper survey or an online survey.
A response rate of 51% was achieved with 537 completed surveys returned.
Quantitative data were analysed using the Stata software package and free-text answers using categorical analysis. These data were member-checked by three reviewers to ensure consistency of coding and to demonstrate rigour.

Findings

The majority of respondents (87%) reported being directly involved in an episode of patient-related violence in the preceding six months, with 47% of respondents having been directly involved in an episode in the week prior to completing the survey. Fifty eight percent of nurses surveyed reported that violence was an inevitable part of their job and the majority (79%) expressed the belief that the incidence of violent episodes was increasing.

Twenty one percent of respondents who had been involved in violent episodes in the preceding six months suffered an injury, though only 4% of these nurses took time off work as a result. Psychological injury was the most common type of injury reported (48%). Of those who sustained a physical injury, bruising was the most frequently reported (72%). The most common emotional responses included anger (65%) and unhappiness (39%) and respondents reported a lack of empathy towards their patients (45%) and decreased morale (38%).

Alcohol intoxication (84%), mental health issues (77%) and substance abuse (76%) were listed as the most common presenting problems of violent patients and 43% of respondents had experienced violence from the parents of paediatric patients. The three highest risk nursing activities were perceived to be triage, communication with patients and managing reactions to delays.

The majority of nurses reported *"some"* but not *"all"* episodes of violence, citing time constraints (57%), the numbers of episodes (52%) and their belief that no action would be taken by management (46%). Only 17% of respondents felt that existing policies and procedures related to the prevention and management of patient-related violence were effective and many felt that management were not supportive or approachable after an episode of patient-related violence.

Implications

The results of this nationwide survey are consistent with the literature on the topic and reaffirm that violence from patients is a legitimate workplace hazard. A disconnect exists at present between the realities of working in an Australian ED where nurses often feel unsafe whilst performing their duties and the level of support provided by hospital management.

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The Violence in Emergency Nursing and Triage (VENT) Study: Qualitative results

Paper

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Focus: Practice

Abstract

Background and context

Whilst violence in the healthcare sector is a legitimate concern for all healthcare professionals, it is especially significant for the nursing profession which has been identified as the group most vulnerable to such violence. This paper reports the qualitative findings of the VENT Study: a national study of Australian Emergency Department (ED) nurses' experiences with patient-related violence.

Methodology

Part I of the VENT Study involved the distribution of surveys Australia-wide to the 1150 members of The College of Emergency Nursing Australasia (CENA). That survey contained an Expression of Interest for the qualitative part of the study which involved taking part in semi-structured interviews for the purpose of discussing experiences of patient-related violence from 2 sub-groups of interest: young people aged 16-25 years of age and the parents/carers of paediatric patients. A sample of eleven ED nurses was recruited comprising seven female and four male participants, with a median age of 44 and an average of fifteen years clinical experience in the ED environment. Interviews were conducted in 2010 and were audio-recorded and subsequently transcribed. These data were augmented with field notes taken by the researcher and analysed using a qualitative descriptive methodology.

Findings

Five participants were interviewed about their experiences with young adults (16-25 years); four about their experiences with the parents/carers of paediatric patients and two about their experiences with both groups. Data analysis led to the identification of nine themes: -

1. *"Performing"* and attention-seeking behaviours from patients;
2. The idea of *"Frequent Flyers"* and repeat offenders;
3. Alcohol-related incidents;
4. Substance abuse;
5. The distinction between *"Mad"* versus *"Bad"* patients;
6. Verbal abuse of participants;
7. Physical abuse of participants;
8. Feeling unsafe at work;
9. Parental emotions - fear, anxiety, impatience and lack of understanding/knowledge.

Implications

Violence from young adults (16-25 years) and the parents/carers of paediatric patients is emerging as a source of concern for Emergency Department nurses. The frequency of episodes of violence from these groups is perceived to be increasing and it is having a negative impact on other patients in the department. Occupational Health and Safety legislation requires employers to provide a safe work place for all employees; however the Emergency Department has been labelled an unsafe working environment for nurses.

Learning objectives

1. Violence from young adults (16-25 years of age) and the parents/carers of paediatric patients is emerging as a source of concern for Australian ED nurses.
2. The frequency and severity of patient-related violence is perceived by Australian nurses to foster an unsafe environment for nurses and others attending the ED.

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Health sector violence on nurses in Fiji

Poster

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Focus: Practice

Background

Workplace violence is any act in which a person is abused, threatened, intimidated or assaulted in his or her employment. It can trigger a range of physical and emotional outcomes in the victims. Studies have found it to be so all-encompassing in these occupations that it is often seen as part of the job and therefore acceptable rather than harmful activity needing assessment and management in the work environment.

Research method

A survey looking at violence in the workplace was conducted at the Colonial War Memorial Hospital, Fiji where 22 nurses who were comprised of 20 females and 2 males were asked 6 questions on the types of violence they face at their work areas. They were asked if they had ever been abused (verbally, etc.); how frequent abuse happened; the cause of the abuse; did the nurses report the matter to their supervisor; did the supervisor take action and what could be done to minimize the problem.

Results

The majority 68% of the nurses suffered verbal or other forms of abuse by patients or the public, 23% experienced abuse by their own nursing fellow workers and another 9% were abused by doctors in the workplace. Nurses have been going through this problem for quiet sometimes as 64% mentioned not experiencing it so often, 14% once a week and 18% met with abuse every day according to their area of work or work station. The major causes of such incidents as stated by 55% of the Accident & Emergency and General Out-Patient nurses were long waiting hours while 41% stated other factors e.g. nurse working alone. The patient to nurse ratio of 1:20 at an Acute Ward prevents the nurse from attending to more than one patient at a time. 55% of the nurses who were scolded at by patients did not report the matter because they thought being verbally abused was part of the work. Another 45% of the nurses have thought of reporting the issue. Most of the workers were disheartened to find that only 32% of the reports were acted upon (in order to improve work) and the actions taken for the remaining 68% of the reports were not known. 27% of workers stated the only solution to improve the working environment and minimize such abuse was to increase the number of staff at the Accident & Emergency Department and the General Out-patient Department. Another 32% stated increasing public awareness of health services and health professionals and 41% suggested training of nurse managers and head of departments.

Conclusion

Nurses frequently feel at loss when it comes to controlling of bullying behavior to other nurses and this can lead to absenteeism, increase in stress level and finally resignation. All of these reactions can contribute to nursing shortage. This is a pilot study. It is hoped that further studies will be conducted in this area for the improvement of work conditions for nurses in Fiji's health sector.

Learning objectives

1) To demonstrate that there is violence mostly in the form of verbal abuse suffered by nurses in the work place.
2) To demonstrate that there is a need to identify strategic interventions or solutions to address abuse in the workplace to improve the work conditions.

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Violence against nurses working at an emergency hospital

Poster

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Focus: Practice

Abstract

Background

Nurses are the health care providers who spend more time with the patients. This may expose them more to violence specially in emergency services. This study was carried out to estimate the prevalence of violence against nurses working at emergency hospital of Mansoura University, Egypt and to determine its types, associated factors, violence circumstances, perpetrators characteristics and response of the victims.

Methods

A descriptive cross-sectional study was carried out in this hospital during March 2012. The data were collected using the adapted version of a self-administered questionnaire developed by the International Labor Office/ International Council of Nurses/World Health Organization/Public Services International on workplace violence in the health sector.

Findings

The response rate was 91.4%. Most of nurses (89.6%) were exposed to violence during the past year. The prevalence of physical, verbal, bullying and sexual violence are (48.2%), (60.2%), (35.9%) and (13.3%); respectively. Both physical and verbal violence occur more among younger nurses of shorter duration of work. Female nurses are more exposure to sexual harassment while male nurses are more exposure to bullying.

Most of physical, verbal and bullying violence occur inside the hospital, while most of sexual harassment occur at patients room. Patients relatives/visitors are the most frequent perpetrator of all types of violence. The response of the victims varies according to the type of violence. The hospital policy for safety of nursing staff against violence is deficient. Also, there is no reporting system and no support to the victims.

Conclusion

Nursing staff working in this emergency hospital suffered a high prevalence of different types of violence. The hospital policy dealing with these types of violence must be urgently formulated and implemented.

Learning objectives

1. Participants will gain knowledge on how nursing staff working in this emergency hospital suffer and on the prevalence of different types of violence.
2. Participants will realise the necessity of the formulation and implementation of a hospital policy dealing with these types of violence.

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Chapter 3 - Physical aggression/ violence

Malpractice and unprofessional conduct: Female genital mutilation in Egypt

Poster

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Focus: Research

Abstract

Background and context

Female genital mutilation (FGM) includes procedures that intentionally alter or injure female genital organs for non-medical reasons. It is performed mainly to girls at the age around 10-15 years. The procedure has no health benefits for girls and women. It carries the hazards of severe bleeding, wound infection, dyspareunia due to painful scar, difficult urination due to malformation, cysts of the vulva and chronic infections as HIV and hepatitis.

Methodology

A total of 145 adult women aged 15-45 years were surveyed in the period from July 2010 to January 2011. A standard questionnaire in semi structured interview was used in surveillance to assess the prevalence of female genital mutilation in samples from both Upper and Lower Egypt.

Results and Findings

Almost all ever-married women age 15-49 – about 96 percent – have been circumcised. Among daughters under the age of 18, 28 percent were circumcised at the time of the survey. Attitudes about circumcision appear to be changing. A small proportion of women supported continuation of the practice. The percentage already circumcised can be combined with the percentage of girls whose mothers expressed an intention to circumcise their daughter(s) in the future to provide an estimate of the expected prevalence of circumcision at age 18 for each cohort of girls. The results suggest that the prevalence of circumcision will decline over the next 15-20 years, from the current levels of around 80 percent to around 60 percent. Beliefs that support continuation of the practice are shared by the majority of women. About 85% believe that circumcision is an important part of religious tradition. 62% feels that the husband prefers the wife to be circumcised, and around half of women think that circumcision prevents adultery. Asking about who is doing the mutilation shows that the white coat persons who should carry the flag of sound health counseling occupy a great sector of the pie. About 37% of female genital mutilation was done by physician or nurse service providers, compared to 45% done by traditional birth attendants (Daya) and 18% done by barbers.

Implications

There are evident female genital mutilation hazards from the deeply rooted gender based violence in Egypt. In spite of various medical, legal, religious and social approaches, many questions are still pending. Does the problem solution exist in law and penalty? Who is the criminal? Is he the health provider, the parents or both? There is an urgent need of contributions of reproductive health agencies to reduce this violence by offering proper support and counselling.

Learning objectives

1. To demonstrate the prevalence of the female genital mutilation procedure in Egypt.
2. To recognize misconceptions of female genital mutilation and the perpetrators of this medical malpractice.

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Elder abuse in Long Term Care: Results from of an actor analysis for Germany

Paper

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Focus: Research
Keywords: Elder abuse, long-term care, actor analysis, prevention, methods of social sciences

Background and study aim

The abuse of older people and persons in need of care is increasingly perceived as a societal problem today. Many elderly people have to rely on help and support due to physical or psychological restraints. As dependence on care and attention by others increases, so does the risk of becoming a victim of elder abuse within a family or an extra-family setting – all the more so when the need for long-term care (LTC) has become manifest.

The need for prevention is undisputed, but there is neither any mechanism in the member states of the European Union to routinely identify and record an abuse of older people requiring (LTC) nor is there a legal basis for introducing such mechanisms of prevention of elder abuse. This was from where the project *Monitoring in Long-Term Care – Pilot Project on Elder Abuse (MILCEA)* departs. This project was funded by the European Commission. The participating countries of the project besides Germany were, Austria, Luxembourg, the Netherlands and Spain.The declared goal of the project was to contribute to the prevention of elder abuse (EA) in LTC (for more information see: www.milce.eu).

Of course, prevention includes the recognition of EA and the risk of EA. But the way we defined it, prevention of EA goes beyond the mere recognition of risk factors and indicators: it also includes concrete actions, taken as part of a *systematic prevention*, to protect the older person. In the frame of the project we examined how the abuse of elderly people requiring care is handled within the LTC system in Germany. To this end, the organizational actors of LTC were analysed and described in terms of their approach to the issue of abuse. Since it is not feasible to do prevention simply by changing certain behaviour by the actors or the institutions, an important aspect of the project has been to study the overall system of LTC. Taking important indicators and risk factors of EA, as well as a definition of systematic prevention as a yardstick, we analysed the structures that are in place in Germany to identify and prevent EA and to protect the older person in need of care. Key research questions were: Who are the stakeholders in LTC? Which actors already have legal responsibility in the prevention of EA? What kind of responsibility do they have? Do they assess indicators and risk factors of EA on a regular basis? What action do they take to protect a potential victim? What do the links and cooperation between the actors look like?

Method

In order to answer our research questions an *actor analysis (Akteursanalyse)* was performed. This is a method that is used primarily in the field of political science and development sociology – e.g. in studies of international cooperation or in the context of environmental policy (e.g. Hübner-Schmidt et al., 2003; GTZ). Generally speaking, this method is most suitable wherever the planning and implementation of reform in specific settings is concerned. The method allows the relevance of organizational actors or their potential for change to be demonstrated within a specific setting. In this case, at issue was the potential of organizational actors in the LTC system to prevent the abuse of older people who require care: to this end, the strengths and weaknesses of every actor were identified, and the communication/cooperation links between the individual actors were highlighted.

Actor analysis was based on a mixed methodological approach, which means that different scientific methods were combined: focus-group discussions, expert interviews and analysis of documents. Actor analysis was carried out for all three care settings: the *institutional care setting*, the *professional home care setting* and the *informal care setting*.

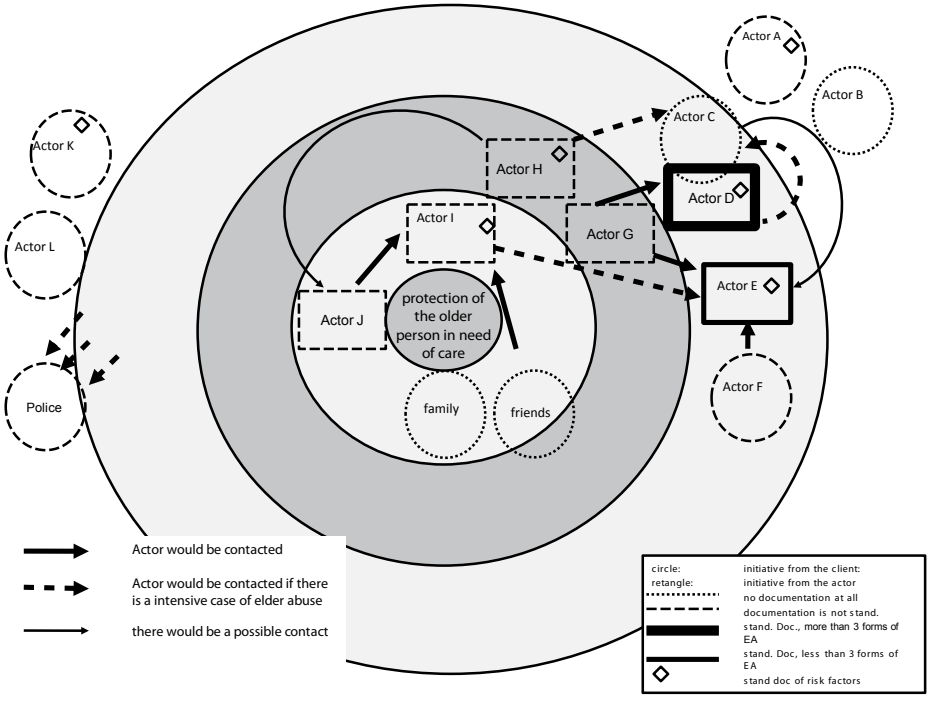
As a first step of actor analysis, the necessary data was collected to describe the status quo of prevention, which takes place in the LTC-system. Focus-group discussions were held to identify – using snowball sampling – possible key actors in the LTC system who could be involved in any system for prevention EA in LTC. At this stage in the research, they would be actors in LTC who are in regular contact with older people in need of nursing care, or else professionals outside the system who come into contact with the older person in need of care if abuse is suspected. The underlying assumption was that, as contact with the older person in need of care increases, so there will be greater chance of detecting EA (or the risk of abuse) and then initiating or implementing measures to protect the older person. The outcome of this step of actor analysis was a list of relevant actors, along with a definition of their tasks, in line with the specific regulations (for detailed information see Schempp, Brucker & Kimmel, 2012).

Further data collection continued with an examination of documents that are publicly accessible, in order to glean information on the various tasks of the identified organizational actors and their work processes, as well as on the legal framework of their work. In tandem with this, selected contacts in the organisations concerned were questioned in semi-structured expert interviews. In terms of the definition of prevention of EA in LTC, it was especially interesting to learn what kind of information the actor collects on EA or the risk for EA and by which means and if there is there is some form of standardised documentation of risk factors or indicators. It was assumed that standardised documentation of indicators and risk factors for EA generally means that greater attention is paid to these indicators by the assessor than if there is no standardised documentation. If there is no documentation at all, it is assumed that perception of these indicators and risk factors is generally very low. In line with our definition of a systematic prevention, the actors were also screened to ascertain the function of the documented information, as well as any consequences that might flow from it, and relevant processes inside and outside the organisation were analysed. These criteria allowed for a description of actors in terms of their potential to systematically detect and avoid EA in LTC. Interviews of representatives of the following institutions were conducted: *nursing homes*, the *Medical Service of Compulsory Health Insurance Funds ([Medizinischer Dienst der Krankenversicherung]*; conducts quality audits in nursing homes and professional home care and nursing services), *day care facilities, consulting services related to care issues,* the *Home Supervisory Authority ([Heimaufsicht];* responsible for supervising residential care), *legal guardian* (persons responsible for patient advocacy). Besides that, *general practitioners* were interviewed.

As is customary with actor analysis, a so-called *actor map* was produced for each care setting. These maps present an overview of all the information on the relevant actors in the care setting. Thus it is possible to judge the relative importance of each actor and the *prevention potential* of the overall LTC system. It was also necessary to determine how information is relayed between the actors once abuse is suspected. The mapping of actors reveals where exactly the LTC system can be improved concerning the prevention of EA.

The following example (Figure 1) of such a map shows the actors according to the criterion of *frequency of contact with the older person*. The centre depicts the target of the intended change, the prevention of abuse. The more contacts an actor has with the older person, the closer he/she will be positioned to the centre of the circle. This arrangement is based on the assumption that, as contact increases, so too does the potential to identify and prevent abuse.

Figure 1: Actor map showing the actors in LTC at different levels, based on the criteria "Frequency of contact with the older person" and "information flow in the event of suspicion of EA" (example)



Nevertheless, frequent contact alone is not sufficient, and that is why the other criteria described above are also considered. The thickness of the frame surrounding an actor indicates his/her potential to identify abuse or the

threat of abuse: the thicker the frame, the more indicators and/or risk factors are recorded by standard or non-standard procedures. In the example below, Actor I and Actor J, who have frequent contact with the older person and are thus placed within the inner circle, have less potential to identify abuse, since they do not apply any instruments. Conversely, someone in the outer circle – Actor D – records indicators and risk factors using standard methods, even though he/she is in contact with the older person infrequently (albeit regularly). This map might suggest improvements that could be made, such as an intensification in the cooperative relationship between Actor I and Actor D.

Results

Based on this mapping exercise it was then possible to assess the importance of the professional actors in the German LTC system in meeting the defined goals of systematic prevention of EA and to determine the *shape* of the shield that can protect older people from EA within LTC system. In the following the most important findings are reported.

It can be stated that up until now, legal regulations concerning the prevention of EA are missing: no professional institution in the German LTC-system has *direct* legal responsibility to prevent EA. But there are professional institutions that have *indirect* legal responsibility to prevent EA. For example service providers are directly responsible for ensuring that the well-being of the older person does not suffer over time. Since EA crucially affects the well-being of an older person, clearly the implication is that EA should be prevented. The *home supervisory authority* has the duty to grant and protect the dignity, interests and needs of the residents in nursing homes by conducting nursing home inspections. So, it has the duty to check, whether the requirements put on nursing homes are fulfilled.

Since, there is no institution in Germany with the direct legal mandate to assess EA, there is no institution that specifically assesses EA or the risk of EA in LTC. Although Germany has established a mechanisms to check the quality of LTC on a regular basis, and these include indicators and risk factors that may point to EA, the goal of the quality inspections is not to assess EA or the risk for it, but to assess the quality of care. It seems that in it is rather discussed about bad quality of care instead of using the term elder abuse. Furthermore, responsibilities concerning EA are not clearly defined or communicated within the different organisations and within the LTC-system as a whole.

Overall, it can be stated: the frame for systematic prevention already exists in all care settings. Thus it is not necessary to develop new structures for the prevention of EA; rather, in setting up a systematic prevention approach, existing structures should be strengthened. This is equally true of the informal setting. The general practitioner is one of the few professional actors who see beyond the closed doors of the family household. The general practitioner therefore has a key position in the informal setting (though he/she may not yet be aware of it). A stronger positioning and a heightened awareness on the part of these professional actors will be necessary to ensure prevention in the informal setting, too. Besides that during the expert interviews it became clear, that some nursing and health care professionals still are generally poorly attuned to EA, its indicators and risk factors. This does not mean that health care professionals are not aware of the problem. Rather, the results indicate an absence of clear structures and responsibilities, with the result that it is not always clear for staff members, how to react in the case of EA.

Furthermore, in Germany there are consulting services outside the LTC system which support possible victims or offenders of EA and refer their clients to institutions *within* the professional LTC-system. But as actor analysis had pointed out, these services require the exercise of a degree of initiative: elderly people in need of care, family members who provide care, nursing personnel, must get in touch of their own accord with a consulting point or hotline. Whether or not they do so depends on a number of factors, e.g. the degree of awareness, that the consulting service is existing, the personality of the client or specific characteristics of the social environment of the potential client. This phenomenon is well known from other areas of social or public health research concerning e.g. the utilization of social services. In the context of EA these consulting are very important, but in the future concrete strategies are needed how the barriers that discourage of the population from seeking help and to utilize these services can be lowered.

The findings suggest prevention of EA must be first of all part of the political agenda. Secondly, awareness and knowledge of EA must be given as a main prerequisite. That's why it is necessary to include EA and its risk factors and indicators in the education of all health care professionals. Furthermore, the responsibilities of all professional actors in LTC concerning the protection of the older people in need of care from any harm and distress must be clearly defined and communicated. To avoid risks of EA service providers of LTC should include the topic into their quality management system.

In a next step, all of the recommendations which can be drawn from the results of the actor analysis have to be worked out in detail in order to implement a systematic approach of prevention of EA in LTC.

Acknowledgments

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For more information on the project MILCEA see www.milcea.eu; www.mds-ev.de.

Learning objectives

1. To demonstrate how the prevention of elder abuse is handled in the German long-term care system.
2. To demonstrate the necessity of a systematic approach of prevention that transcends the mere recognition of indicators and risk factors of elder abuse.
3. To introduce the method of actor analysis
4. To show how prevention of elder abuse in sense of a systematic approach can be improved.

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Effect of supplementation with selenium on postpartum depression and violence: A randomized double-blind placebo-controlled trial

Poster

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Focus: Practice

Abstract

Objective

Postpartum depression is a common complication of childbirth and sometimes linked with aggression against family and health care staff that is involving in routine post partum controlling. Its prevention is an important public-health issue because of its negative effects on mother, infant, family and health system of routine post partum controlling. The present randomized, double-blind, placebo-controlled trial was conducted to examine the effect of prenatal selenium supplementation on the postpartum depression and level and violence against health care center's staff.

Design

A total of 166 primigravid pregnant women in the first trimester of pregnancy, were randomized to receive 100 mg of selenium (n 83) or a placebo (n 83) per day until delivery. The symptoms of postpartum depression were evaluated during the eight weeks following delivery by means of the Edinburgh Postnatal Depression Scale (EPDS) and The Aggression Questionnaire (AQ) . Serum selenium concentrations were measured at baseline and at the end of study.

Results

There was no significant difference in demographic characteristics and perceived social support between the selenium and control groups at baseline (p 4 0.05). There were 22 drop-outs in the selenium-supplemented group and 19 in the placebo group. Forty-four women in the selenium group and 41 women in the placebo group completed the trial and the EPDS questionnaire and The Aggression Questionnaire (AQ). Selenium supplementation was associated with a significant increase in mean serum selenium concentration at term (p 5 0.001) but remained unchanged in the control group. The mean EPDS score in the selenium group was significantly lower than that of the control group ($p < 0.05$). Furthermore the aggression score in the first group was lower than the second one and this differences was statistically significant in both physical and verbal aggression.

Conclusion

These data suggest that supplementation with selenium during pregnancy might be an effective approach for the prevention of postpartum depression and the level of aggression and violence.

Learning objectives

1. Supplementation with selenium during pregnancy might be an effective approach for the prevention of the level of aggression and violence in post partum period.
2. There is a relationship between depression and violence in post partum women.

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Prevalence and consequences of violence and aggression among German healthcare workers: A survey

Poster

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Focus: Research

Background and context

For many people who work in the nursing and healthcare professions, aggression and violence are part of their everyday professional life. In Germany, neither instances of violence nor the consequences of violence in the nursing and healthcare professions have yet been recorded systematically, and studies have been undertaken mainly in psychiatric clinics and general hospitals. In this study the prevalence and consequences of aggressive assaults on healthcare workers in different settings in Germany are investigated.

Methodology

Between September 2008 and February 2009 a retrospective survey of workers in the German healthcare system on how they experience violence and aggression was carried out. The sample consisted of 1,973 workers from 39 facilities (six facilities for the disabled, six hospitals and 27 outpatient and inpatient geriatric care facilities). The questionnaire was drawn up along Staff Observation Aggressive Scale-Revised (SOAS-R) lines and recorded socio-demographic data and also details of the frequency and nature of the assaults, of the stress experienced and of the support on offer. Odds ratios (ORs) and 95% confidence intervals (CIs) were calculated for factors that might influence the frequency of violence and the stress experienced after assaults.

Findings

Over the previous twelve months, 56.2% of respondents had experienced physical violence and 78% verbal violence. 44% of respondents said they experienced physical violence and 68% verbal violence once or more per month. The highest prevalence of physical violence was in inpatient geriatric care (63%) and the lowest in outpatient care (40%). Younger workers run a higher risk of being affected by physical violence than older colleagues (OR 1.8; 95% CI 1.3–2.4). There is also an increased risk of experiencing physical violence in inpatient geriatric care (OR 1.6; 95% CI 1.2–2.0). Around a third of workers feel seriously stressed by the violence experienced. This feeling of stress is most marked among workers in workshops for people with disabilities and in outpatient care (36.9% and 37% respectively). About one third of the respondents fell well prepared by their facility. The risk for employees to experience either verbal violence (OR 0.5, 95% CI 0.4–0.7) or physical violence (OR 0.7; 95% CI 0.6–0.9) is reduced, if facilities train workers for interaction with aggressive and violent clients. In addition, good preparation by the facility has a positive effect on the stress that staff experience (OR 0.6; 95% CI 0.4–0.8) after verbal or physical aggression.

Implications

Violence and aggression toward nursing and healthcare personnel occur frequently. Every third nurse or healthcare worker feels severely stressed by violence and aggression. Occupational support provisions to prevent and provide aftercare for cases of violence and aggression reduce the risk of incidents and of perceived stress. However, only about a third of the respondents appear to receive adequate provision of support. Research is needed on occupational support provisions that reduce the risk of staff experiencing verbal and physical violence and the stress that is associated with it.

Learning objectives

1. To demonstrate that the frequency of violence healthcare workers are confronted with is high.
2. To demonstrate that training at the workplace can reduce frequency of verbal and physical aggression and the impact of these acts on healthcare workers.

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The antecedents of violence and aggression within psychiatric in-patient settings

Paper

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Focus: Research

Background

One of the most important goals of in-patient psychiatric services is to provide a safe and therapeutic environment for patients. The attainment of this goal can be jeopardised by the disruptive behaviours of patients. Such 'conflict' behaviours are any actions that put patients or others at risk or result in harm. This includes verbal and physical aggression, which have been shown to be particularly prevalent within inpatient psychiatric settings. Verbal and physical aggression have also been found to draw the widest range of 'containment' measures, that is, the actions that staff take to manage conflict events (e.g. restraint, seclusion, medication, time out and observation). When verbal aggression escalates into physical violence, it can be directed towards other patients, objects and / or staff, which may result in potentially serious injuries to others and themselves. Violence and aggression can cause a multitude of negative staff outcomes including high absence, high stress, low morale, high turnover and high vacancy rates. These outcomes will contribute to hampering the efficiency of the service and will likely result in more adverse incidents. Additionally, verbal abuse has been estimated to cost the UK approximately £10 million per annum, while aggression to objects and physical assault are estimated to cost over £3 million and £5 million per annum respectively. Therefore, such events are physically, psychologically, clinically and economically costly and serve to endanger the goals of in-patient psychiatry. Understanding what factors increase the likelihood of events such as aggression and violence occurring is a crucial step towards to improving their predictability and enabling staff to be able to prevent them from occurring. An important subsidiary benefit of meeting this objective will be the reduced level of required staff containment measures. This is important as containment measures have been shown to lead to conflict as well as carry a high financial cost – an estimated £106 million per annum in the UK. The aims of this systematic review were to investigate the types of prospectively recorded antecedents of aggressive and violent incidents within inpatient psychiatric settings and to estimate the proportion of aggressive and violent incidents that they each account for.

Objective

To systematically review the types of prospectively recorded antecedents of aggressive and violent incidents within inpatient psychiatric settings and to estimate the proportion of aggressive and violent incidents that they each account for.

Method

Empirical articles and reports with primary data pertaining to violence and aggression within adult psychiatric in-patient settings were retrieved. For each study, prospective antecedent data were extracted. The extracted antecedent data were thematically analysed by grouping emerging themes into a hierarchical higher- and lower-level coding system. Using Stata v.11, a meta-analysis was conducted using the articles that reported both the total number of aggressive or violent incidents and the number and type of antecedents related to each incident. These data enabled the calculation of the proportion of incidents that each higher-level antecedent theme was related to. The pooled proportion estimates and their 95% confidence intervals were calculated using a random effects model, which facilitated external generalisability and protected against sample heterogeneity.

Res ults

The electronic searches identified a total of 4353 articles. The number of articles that met the inclusion criteria was 428. Of these, 71 articles provided live, prospective antecedent data and were included in this review. From these studies, 59 distinct antecedent themes were identified and organised into nine higher-level themes. Fifty-one articles reported the data necessary for the proportions meta-analysis. The higher-level antecedent theme 'staff–patient interaction' was the most frequent type of antecedent overall, precipitating an estimated 39% of all violent/aggressive incidents. An examination of the staff–patient interaction themes revealed that limiting patients freedoms, by either placing some sort of restriction or denying a patient request, was the most frequent precursor of incidents, accounting for an estimated 25% of all antecedents. The higher-level themes patient behavioural cues and no clear cause also produced other large estimates and were attributed to 38% and 33% of incidents overall.

Conclusion and implications

The findings of this review underscore the influence that staff have in making in-patient psychiatric wards safe and efficacious environments. As the results suggest that most violent incidents are preceded by the staff

exercising their power over the patient, prospective interventions aimed at reducing in-patient violence and aggression should centre on enhancing staff–patient interactions. Such interventions should focus particularly on finding better ways to manage patient requests, making them feel more individualised and less institutionalised, and increasing staff's technical mastery of containment procedures. It may also be important to reduce the real or perceived level of power differences that exist between staff and patients, either by giving patients more powers and freedoms, or by staff exercising their position of power less liberally and only when the situation necessitates it.

Educational goals

1. The majority of violent and aggressive incidents across in-patient psychiatric settings are triggered when staff interact with patients.
2. Staff more readily record patient behavioural cues as antecedents compared with mood/emotional cues.
3. When staff is unsure of what precipitated an incident, they should pursue other potential sources of antecedent information.
4. Articles predominantly reported the staff ‹s perspective of antecedents. Therefore, the true nature and level of antecedents is questionable.

Learning objectives

1. Participants will understand that the majority of violent and aggressive incidents across in-patient psychiatric settings are triggered when staff interact with patients.
2. Participants will understand that the staff/patient interaction which triggers most incidents is «limiting patients freedoms», by either placing some sort of restriction or denying a patient request (such interactions accounted for an estimated 25% of all antecedents).

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Violence and risk assessment in a population of civil psychiatric patients experiencing deinstitutionalization

Paper

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Focus: Research

Background

Community-based care, deinstitutionalization, or the provision of psychiatric care in the least restrictive, most *"home-like"* environment is currently considered best practice for the delivery of psychiatric services in developed countries around the world (World Health Organization, 2001). However, this issue still garners significant controversy. Some researchers, politicians and members of the public have asserted that deinstitutionalization leads to homelessness, inadequate treatment, transinstitutionalization or even death (e.g. (Bryeton, 2006; Grindlay, 2009; Smyth, 2006; Bachrach, 2001; Lamb & Bachrach, 2001). The unfavourable outcomes sometimes attributed to the first wave of deinstitutionalization have generally been ascribed to underfunding and/or poor management at the systemic level rather than limitations in the model of community-based care (World Health Organization, 2003). More recent examples of deinstitutionalization, in countries around the world, have provided evidence that appropriately funded and executed programs of deinstitutionalization have largely avoided negative social and clinical outcomes and lead to some positive outcomes in areas such as quality of life (e.g. Barbato, 1998; Lesage & Tansella, 1993; D'Avanzo et al., 2003; McGrew et al., 1999a, 1999b; Pescosolido et al., 1999; Leff et al., 2000; Leff & Trieman, 2000, Hobbs et al., 2000; Newton et al., 2000; Hobbs et al., 2002; Trudel & Lesage, 2006; Lesage et al., 2000; Duurkoop & van Dyck, 2003).

British Columbia (BC), Canada has been slower than some regions to embrace the move towards community-based tertiary services. The decision to close Riverview Hospital (RVH), BC's only tertiary psychiatric hospital, was instigated by the release of a new Mental Health Plan for BC in 1998. In 2002 the Riverview Hospital Redevelopment Plan was initiated. This plan was a collaborative effort involving all five of BC›s provincial health authorities and the Provincial Health Services Authority. The Ministry of Health provided $138 million in capital funding to construct new facilities or to renovate existing facilities where appropriate (BC Mental Health and Addiction Services, 2009). The realignment of services ultimately resulted in the opening of more than 1000 tertiary beds throughout BC and the transfer of every patient out of the hospital.

PATHWAYS is a large-scale prospective research project examining multiple aspects of the RVH redevelopment ranging from quality of life, residential outcomes, stigma, and negative outcomes such as suicide, self-harm, violence and victimization.

Method

Participants: All patients residing at RVH who were identified for transfer to community-based care, meeting the inclusion/exclusion criteria, were approached for participation. Patients had to be capable of taking part in interviews conducted in English. Participation could not create undue distress, as indicated by the assent of their attending psychiatrist. Reading and concentration limitations were accommodated.
Procedure: In a prospective, repeated measures design, baseline assessments were conducted before participants were transferred from RVH to the community. Once a participant was transferred, follow-up assessments were conducted every six months for two years, for a total of four community assessments. The current sample includes 102 baseline assessments, 88 follow-up one assessments and 61 follow-up two assessments. To increase the validity of the measurements, data was collected from a variety of sources, including: file reviews, participant interviews and staff interviews. Each of these sources was examined at baseline and at every follow-up.

Measures

Short-Term Assessment of Risk and Treatability (START). The START is a 20-item risk assessment scheme for multiple adverse outcomes over the short-term (weeks to months). The items are scored both as vulnerabilities and as strengths, from 0 to 2. Assessors provide ratings of risk (Low, Moderate, High) for: 1) violence to others; 2) suicide; 3) self-harm; 4) self-neglect; 5) unauthorized absence; 6) substance use; and 7) being victimized. START has been found to have good internal consistency (alpha > 0.80), acceptable item homogeneity (MIC = 0.20 - 0.50), and good to excellent inter-rater reliability (ICC > 0.80).
Historical/Clinical/Risk Management–20 (HCR-20, Version 2). The HCR-20 is a 20-item risk assessment scheme (coded 0, 1, 2) designed to provide structure to clinical assessments of risk for future violence (months to years). Research indicates moderate effect sizes with aggression, violence, and crime and acceptable inter-

rater reliability and internal consistency. Research has also demonstrated that it is sensitive to changes in the dynamic risk factors included within it.
START Outcome Scale (SOS) / Overt Aggression Scale – Modified (OAS-M) assesses the occurrence, frequency and severity of diverse challenging behaviours, including aggression towards others (verbal, physical, and sexual), self-harm, suicide ideations/behaviours, substance use, self-neglect, victimization, and unauthorized absences. This presentation will focus on the frequency and severity of aggression.

Results

The prevalence of level one verbal aggression (shouts angrily, curses mildly, or makes personal insults) significantly increased from baseline to follow-up one (57% vs. 61%). The prevalence of level two verbal aggression (curses viciously, is severely insulting, has temper outbursts) significantly increased from baseline to follow-up one (22% vs. 35%). In addition, the frequency of these behaviours significantly increased. The prevalence (14% vs. 25%) and frequency of level three verbal aggression (impulsively threatens towards others) significantly increased from baseline to follow-up one. There was no change in either prevalence or frequency in level four verbal aggression (makes clear threats of violence towards others repeated or deliberately) from baseline to follow up one.

The prevalence of level one violence against others (makes threatening gestures, swings at people, grabs at clothing, throws objects dangerously) significantly increased from baseline to follow-up one (19% vs. 27%). In addition, the frequency of level one violence against others also increased significantly. There was no significant change in the prevalence or frequency of any other level of violence against others.

The prevalence of level one sexual aggression (makes sexually inappropriate or suggestive invitations, gestures or statements) significantly increased from baseline to follow-up one (16% vs. 19%). However, there was no change in the frequency of these events. The prevalence of level two sexual aggression (makes sexually threatening statements, exposes genitals to others, masturbates in public or is voyeuristic) significantly increased from baseline to follow-up one (2% vs. 5%). However, there was no change in the frequency of these events. The prevalence of level three sexual aggression (sexually touches or fondles others nonconsensually) significantly increased from baseline to follow-up one (4% vs. 6%). However, there was no change in the frequency of these events. There were no incidents of level four sexual aggression (commits coercive or violent sexual assaults) with/without penetration; oral genital or anal), uses weapons) at baseline or follow up one.

There was a change in the prevalence but not the frequency of level one (FU1 – 67% vs. FU2 – 60%) and two verbal aggression (FU1 – 38% vs. FU2 – 42%) from follow-up one to follow-up two. There was no change in level three or four verbal aggression.

There was a change in the prevalence but not the frequency of level one (FU1 – 30% vs. FU2 – 34%) and two aggression against others (FU1 – 33% vs. FU2 – 31%). There was no change in level three aggression against others and no incidents of level for aggression.

The prevalence but not the frequency of levels one to three sexual aggression decreased from follow up one to follow up two. There were no incidents of level four sexual aggression.

Short-Term Assessment of Risk and Treatability (START) violence risk estimates (low, moderate, high) were significantly correlated with the prevalence of any verbal aggression, any aggression against others and any sexual aggression. In contrast, the HCR-20 risk estimates were only significantly correlated with any aggression against others.

Discussion

There was a trend towards an increase in violence from baseline to follow up one across most types and levels of violence. One possible explanation for these findings is a difference in the charting of violent behaviours. However, the trend of decreasing violence from follow up one to follow up two supports the hypothesis that this increase may have been a function of the transition rather than a quality of the new environment. In addition, a significant number of participants had lived at Riverview Hospital (RVH) for many years, some for 20 years or more. The move from a long-term stable home may have been initially challenging for some participants. It is also possible that the first six months after patients moved from RVH was a transition period for staff as well. As staff got to know the patients better they were more effective at implementing strategies to ameliorate risk.

It is important for both staff and patients to feel safe in their environment. Understanding the frequently and nature of violence perpetration during a significant transition in the provision of psychiatric care is an important aspect of reducing the incidence of violence experienced by patients and staff during future transitions. This research indicates that the first six months following a significant change in care may be time of increased risk for violent behaviours.

START violence risk estimates were found to have a stronger relationship than the HCR-20 with violent outcomes. In addition, START was significantly correlated to a wider range of violent behaviours. This indicates that START may be a more efficient risk assessment measure in this population.

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Learning objectives

1. Understand the frequency and nature of violence in population of civil psychiatric patients experiencing deinstitutionalization.
2. Understand the effectiveness of various methods of risk assessment in this population.

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Prevalence of physical violence against nurses at emergency department at tertiary care hospitals in Karachi, Pakistan

Paper

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Focus: Practice
Keywords: Physical violence, emergency department, hospitals.

Abstract

Introduction and background

Physical violence towards nurses is emerging problem in the emergency department in health care settings. Nurses are the backbone of the health care system and physical violence may be one of the factors which impact motivation, retention and performance of Registered Nurses in Emergency Departments.

Objective

The main objective of the study is to determine the prevalence of the physical violence against nurses at Emergency Department in tertiary care hospitals, Karachi, Sindh, Pakistan.

Purpose

To estimate the burden of physical violence against nurses working at Emergency Departments at tertiary care hospitals, Karachi Sindh, Pakistan.

Methodology

Analytical cross-sectional study was conducted to estimate the prevalence of physical violence at the Emergency Departments of four tertiary care hospitals of Karachi. Karachi is the cosmopolitan city of the country where people of all culture, race and religion are residing. Most of the population belongs to low socioeconomic status and visited Public Sector hospitals for their health care facilities. Data was collected from four tertiary care hospitals of Karachi; two each from public and private sectors. 50 Nurses were included in this study; 20 from Jinnah Postgraduate Medical Centre, 10 each from Civil Hospital, Liaquat National Hospital and Patel Hospital, Karachi.

Analysis

Data was analyzed on SPSS version 12. The questionnaire used in this study was adopted from another study Workplace violence in the health sector country case studies research instruments survey questionnaires (English Version) by ILO/ICN/WHO/PSI project.

Results

The majority of the participants were male in the study (54%). Most of these participants were unmarried (60%), having working experiences <5 years (78%). The results related to physical violence at workplace revealed that 76% of Nurses experienced physical violence, 44% experienced body injuries and in incident of violence most of the relatives of the patients were involved (78.4%).

Conclusion

The results show that the incidence of violence against nurses working at Emergency Department being done by the relatives of the patients. To avoid such practice, it is essential that the Emergency Departments should be secured and necessary security measures should also be taken for the safety of health care providers, especially Nurses, who are more involved in taking care of patients. Further large scale studies should be conducted to more closely identify the problems and its predictors.

Advocacy and policy development matters/recommendations

It is recommended that:
- Management should develop the culture of the reporting system via:
  i) Develop the form of incident reporting.

ii) Everyone should know how to fill and how to address the incident.
iii) Proper actions should be taken to influence the others.

- Management should develop the comprehensive policies to deal the cases of assaults in the Emergency Departments.
- Proper security measures should be taken to avoid the occurrence of the incident.
- There should be another top secret path for the staff to escape from the place of incident to save them.
- There should be frequent workshops seminars arranged or allow the staff to attend the workshops on communication skills, stress management, preventive measures in emergency department and skills to deal with aggressive perpetrators, etc.
- Further research to investigate the causes of violent behaviour in health settings.
- Further research to identify components of an effective training programme to assist in the prevention and management of violent behaviour.
- Further study to improve reporting systems in relation to aggression and violence in the health workplace.
- Appointing an interdisciplinary task force to identify vulnerabilities in the emergency department and develop a plan for preventing, mitigating, responding to and reporting violence.

Learning objectives

1. To raise the voice against nurses dignity at workplace. Nurses are there for the care of the sick and violated patients not for the violation from the patients and relatives.
2. Nurses are the backbone of the health care profession so to maintain the butty of the health profession it is important care of the backbone, its my key message for all nurses that recognize your place and be proud and confident and say ‘NO’ to any type of violence.

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Chapter 4 - Sexual intimidation/ harassment

The nature and consequences of sexual violence in Acholipii Refugee Settlements in Pader District

Paper

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Focus: Practice
Keywords: Nature, consequences, sexual, violence

Abstract

Background

The war in northern Uganda has been the subject of numerous studies related to the problem of sexual violence. Historically, such violence is known to be part of strategic war plans to conquer and destroy communities, but it is now unfortunately prevalent in times of relative calm.

Methods

We describe the characteristics and consequences of sexual violence in Northern Uganda through the retrospective analysis of 2,565 patients who received medical care in the International Rescue Committee (IRC) sexual violence clinic in the Acholipii Refugee Settlements between December 2000 to January 2001.Using a standardized questionnaire, we report patients demographics, number and status of aggressor(s), forced detention and violent threats among other variables for all patients presenting for medical consultation after a sexually violent event during this period.

Results

Ninety-six percent of our cohort were female and 29.3% minors, 18-29 years was the most represented age group. Acts of sexual violence (n = 2,565) were reported to be mainly perpetrated by men with military affiliations (73%), although civilians were implicated in 21% of crimes. The attack was perpetrated by two or more persons in over 74% of cases and most commonly perpetrators were unknown armed males, (87.2%). Male victims accounted for 4% (n = 103) of our cohort. Forty-eight percent of our patients reported being attacked whilst performing daily domestic duties outside the home and 18% of victims being detained by their perpetrators, the majority of whom were held for less than 2 weeks (61.6%).

Conclusions

The characteristics of sexually violent acts in Acholipii Refugee Settlements during this period cannot be simply explained as a weapon of war as described in the literature, meaning the use of sexual violence within a military strategy where it is employed under the orders of a commander to harm a particular community. Whilst the majority of aggressions were by armed men there was an important proportion in which civilian perpetrators were implicated. This type of violence has become part of the general characteristics of violence in this war-torn population. Sometimes, as a means for some military factions to acquire remuneration with impunity and for some civilians, as a means to counteract confronting, changing social norms occurring during chronic conflict.

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Series of case-histories of sexual harassment in organizational set-ups

Poster

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Focus: Guidance

Abstract

Most cases of sexual harassment go unreported in cultures that are restrictive, inhibited, and closed. The cases go unreported and are brushed under the carpet. The perpetrator is a person in position, power and the victim is directly working under or with him. The author proposes to present some cases who had come for help to the clinic having experienced the abuse. They are all young females and the information is highly confidential. The acute symptomology and the long term effects of the abuse will be the focus and the distress associated will be discussed.

- The inability of the victim to take action and the organizational hierarchy preventing a person to do so, will be thrashed out.
- What are the steps for safety that can be taken?
- How the organization has to keep the Sexual Harassment Committees in place. How the victim can be saved from further abuse etc.

Learning objectives

1. To acquire knowledge on the symptomology of harassment sexual/emotional/psychological.
2. The demonstrate the steps needed to address this difficulty from overall perspective

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"Please treat me with respect and honor". A nurse's plea!

Poster

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Focus: Practice
Keywords: Sexual harassment, nurses, psychological and emotional well-being, measures to deal with harassment.

Abstract

Background and context

Violence free environment at health sector is mandatory for health care personnel. For the patients to be looked after well, health care providers need to be mentally relaxed. But, the trend of being harassed sexually at work place is found frequently increasing because nurses are more in bodily contact with the patients to provide care. Nurses are dignified members of the society and their safety and respect should be upheld at all times. However, nurses have reported harassment at work place a lot many times in multiple researches which has affected their mental and emotional health. A

study conducted in 8 hospitals in Australia reveals that of all participants 60% of the female nurses and 36% of male nurses complaint of being sexually harassed in two years before the conduct of this study (Cogon & Fish, 2009). However, the aspect of psychological and emotional health after harassment and steps to deal with harassment is overlooked in many researches. Therefore, the purpose of this study is to create awareness about psychological and emotional impact and measures to overcome sexual harassment of on nurses in health sector.

Methodology

A comprehensive literature review was done.

Findings

Literature says that sexual harassment is one of the most severe forms of harassment for nurses that could leave deep down mark on the mental and emotional wellbeing of nurses. Post harassment, nurses are at higher risk of developing Post traumatic stress disorder, depression, suicidal ideations, anxiety, nightmares and flash backs which will ultimately affect their emotional stability. In health care set up, where nurses are expected to provide holistic care to the patients which includes emotional, physical and mental health, a nurse being sexually harassed can hardly serve for the purpose and will have compromised work affectivity. Moreover, reporting of such incidences are also rare and in health care organizations set up to deal with sexual harassment is not so structured.

A Study conducted in 8 health hospitals in Turkey identified that out of 622 participants, 37.1 % were sexually harassed. The most commonly identified reactions were fear and anger and they reported mental health deterioration as consequence of being sexually harassed. 80% of those 37.1% did not even report the incidence and many of them did not take any action for it (Celik & Celik, 2007).

Implications

Proper measures should be taken for nurses safety. There should be a proper and well informed channel of communication for reporting of such incidences where confidentiality should be maintained. Moreover, a neutral body should be there at health care set up to listen to both parties i.e. victim and harasser to solve the case accordingly.

Health care organizations should hire a psychologist to help the victim. In case, of rare but most violent of all sexual harassment i.e. rape or attempted rape doctor should be hired for provision of post coital physical injuries.

As preventive measure, awareness sessions should be should be organized for novice nurses and other staff members and reinforcement should be done every 6 monthly. Zero tolerance policy i.e. no violence tolerance should be adopted and implemented. Initiating and implementing change at policy level is significant and monitoring of its affectivity should be done frequently.

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Learning objectives

- Respect and dignity of nurses should be observed at all times regardless of color, race, creed and class.
- Harassment has serious health and work related consequences so health related people should be aware of their work environment.

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Chapter 5 - Psychological aggression/violence

Stalking by patients: Doctors' experiences in a Canadian urban area

Paper

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Focus: Practice

Abstract

Healthcare workers are vulnerable to being a victim of stalking by their patients, most often from stalkers who are intimacy seeking, resentful or incompetent. Healthcare workers regularly see lonely or mentally unstable individuals who may misconstrue sympathy and attention as romantic interest. Therapists may be vulnerable as a result of erotic transference. The literature suggests that a significant number of clinicians experience some type of stalking and suffer adverse consequences yet most lack any type of training to deal with this.

Physicians in the Greater Toronto Area were surveyed about their stalking experiences to obtain information on various types of stalking, impact on the physicians harassed, types of patients who stalk, perceived reasons for the stalking, and strategies used to deal with the situation.

The experience of being stalking can stir up feelings of fear, anger, anxiety, frustration, helplessness and lack of control. Although both male and female patients were stalkers, their motives and stalking behaviors were dissimilar. Varying reasons behind the stalking may account for the differing rates between physician specialties.

Physicians may benefit from recognition of behaviors that tended to precede the onset of stalking behavior. Increased awareness of this phenomenon and appropriate interventions could reduce escalation of harassing behaviors. The warning signs and suggestions for management of stalkers in the healthcare setting will be discussed.
Enhanced knowledge about the phenomenon of stalking of healthcare professionals by their patients.

Reference

Abrams K, Robinson GE. Stalking by Patients: Doctors' Experiences in a Canadian Urban Area. The Journal of Nervous and Mental Disease. October 2011; 199(10):738-743.

Learning objectives

1. Awareness of the emotional and practical consequences of being stalked.
2. Enhanced knowledge of the reasons, possible warning signs and suggestions for prevention/management of stalkers in the healthcare setting.

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Features of surgeons' personality accentuations

Poster

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Focus: Research

Abstract

One of the main existential features of doctor's profession is to take the responsibility for the lives and health of the patients which suggests a high standard of requirements for the doctor's personality. Especially it concerns the personality of the surgeon, whose professional work involves advanced skills to diagnose and make decisions in emergency situations, often under time pressure. The surgeon is in a difficult emotiogenic situation associated with the existence of a complex of the mutually exclusive polar emotions – negative, due to the suffering and pain of the patients, and positive, initiated by the success of the operations, gratitude of the patients and their families. Such a complex of emotions can lead to permanent mental and emotional stress, inadequate behavioral reactions associated with exacerbation or accentuation of the character traits.

Possible accentuations of the doctor's personality can trigger the aggressive behavior towards patients, which acts as an additional damaging factor determining the deterioration of the patients. The problem of the surgeons' personality accentuation can be attributed to the more general issue of the professional deformation of the personality. The specific character of the professional activities can sharpen and make more prominent the inherent features of surgeon, being a factor that guides the development of the personality in a certain direction.

In order to study the features of surgeons' personality types accentuations we carried out a study in the City Hospital 1, Rostov-on-Don (Russia), which included 60 surgeons. For the diagnosis of the personality accentuation characteristics we used the G. Shmishek technique. Analysis of the study results showed that among practicing surgeons working in the hospital, the most represented was the hyperthymic type of the accentuation. The next one was getting stuck type of the accentuation. In the third place - the excitable type of the accentuation. And the least developed was the dysthymic type of the accentuation.

The results suggest that these accentuations may act as factors, influencing the initiation of the aggression and violence in the relationships between doctor and patient, and between doctors as well, which lead to the destructive conflicts, disruption of the emotional well-being and reduce the effectiveness of the treatment.

Learning objectives

1. To show the importance of the psychological studies of the doctors' personality types to examine the relationships between the doctors and patients and also between the doctors, because the doctors' personality types characteristics may lead to the violations of the emotional relationships, conflicts and possible acts of violence.
2. To show that for the doctors with certain specialties it is characteristic the predominance of the certain personality accentuations and the originality of the individual and psychological personality traits that affect the was they conduct their professional activities and development of the relationships in the professional groups, as well as building relationships with the patients.

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Perceived psychological violence among nurses working in community health clinics in Cape Town and the impact on the nurses

Paper

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Focus: Practice

Abstract

Introduction

This paper will explore the level/perception of psychological violence among nurses working in Community Health Clinics in Cape Town, its effect and impact on the nurse.

Aim and Objectives

To explore levels of psychological violence in nursing within community health care settings. Some of the objectives of the study examined the levels, extent and frequency of psychological violence among nursing staff in community health clinics.

Research Design

A phenomenological approach was selected to capture the shared experiences and opinions of various categories of nurses working in community health clinics. A sample group or research participants was selected from public funded clinics situated in seven sub-districts within the Cape Town Metropole Health District.

Methods of data collection

Data was collected from three sources, i.e. questionnaires, interviews and documents. Although phenomenological approach normally does not use questionnaires as a means of data collection because of the nature of the topic under study, confidentiality has to be assured to avoid the possibility of reprisals or intimidation.

Analysis

Computer software was utilized to capture information obtained from questionnaires and interviews. Questionnaires and interview responses were compared for similarities and differences. Only one official document was made available for the study, therefore no triangulation of data sources was possible.

Results

The study explored various levels of violence committed among nurses. Interview and questionnaire responses confirmed existence of violence amongst nurses. Both interview responses and questionnaire results identified psychological violence as the most common form of violence among nurses in all participating clinics. Various levels of Psychological violence were committed among nurses. Professional jealousies, abuse of power, discrimination among colleagues were identified, bullying. The following behaviours were contributing factors that constituted to psychological violence: verbal abuse, shouting, swearing, humiliation, intimidation, discrimination, bullying, ignoring, labelling, and insinuations against nurses.

Conclusion

The results are comparable to international and local findings. Questionnaire findings were cross referenced with interview findings demonstrating in this process the achievement of objectives of the study. These findings are consistent with international findings confirming the presence of violence among nurses and the extent of violence amongst nurses.

Learning objectives

1. Share experiences of violence among community health nurses in Cape town Community Health Clinics
2. Share the effect of this violence on patient care.

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Prevalence of workplace violence towards nurses at the government and private healthcare settings in Karachi, Pakistan

Paper

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Focus: Research

Introduction

Workplace violence is a common phenomenon amongst all kinds of professional groups. Healthcare sectors are more likely to have high incidences of workplace violence than other professional groups (Rippon, 2000). In healthcare sectors internationally, workplace violence is considered a serious issue. Workplace violence not only affects the physical and psychological health of healthcare providers but it also contributes towards serious negative consequences for the overall healthcare delivery system and that includes compromised patient care (Hahn et al., 2008). According to the International Labour Office (1998) *"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 (p. 8)."*

Among all healthcare workers, nurses are potentially the most at risk to experience workplace violence because they act in a frontline position at any healthcare setting. Nurses need to interact with patients, their family members, doctors, and other paramedical staff. Because of this frontline position, nurses are more prone to work related violence (Ryan & Maguire, 2006).

Workplace Violence towards Nurses from a Pakistani Context

Workplace violence towards nurses is a common issue worldwide. While the actual prevalence of workplace violence towards nurses remains unknown, it is expected that a lack of respect towards the nursing profession in the Pakistani society is a significant factor that contributes to workplace violence towards nurses. In developing countries nurses are often treated as an oppressed group. This discrimination against the profession hinders nurses from providing quality care in healthcare settings; hence, it badly impacts the overall health status of the nation (Lee & Saeed, 2001). Secondly, the media has been portraying a negative image of nurses in the society. They are shown as symbols of sex and as obedient servants of physicians. This poor image of the profession is a contributing factor for workplace violence towards nurses (French, Watters, & Mathews, 1994). Lastly, cultural imperialism is another contributing factor for violence towards nurses. In the government health sectors of the Pakistani society, nurses are often treated as inferior and are marginalized. Physicians and administrators are considered a dominant group in healthcare settings. It has been a norm for this dominant group to exhibit aggressive and violent behavior towards nurses. In addition, usually the patients and their family members harass nurses for delay in providing care while they do not necessarily blame the physicians perhaps because they are more afraid of being refused treatment from them (Lin & Liu, 2005).

Study purpose

This study aims to identify the prevalence and characteristics of physical violence, verbal abuse, bullying/ mobbing behavior, and sexual violence experienced by nurses working in all the In- patient units and the Emergency Departments of two private and two government healthcare settings in Karachi, Pakistan.

Study questions

This study will provide answers to the following questions:

1. What is the prevalence of physical violence towards nurses working in the government and private healthcare settings in Karachi, Pakistan?
2. What is the prevalence of verbal abuse towards nurses working in the government and private healthcare settings in Karachi, Pakistan?
3. What is the prevalence of bullying/ mobbing behavior towards nurses working in the government and private healthcare settings in Karachi, Pakistan?
4. What is the prevalence of sexual violence towards nurses working in the government and private healthcare settings in Karachi, Pakistan?

Methodology

Study Design

A Cross- sectional study design was used in this study.

Study Population and Setting
The population for this study included all registered nurses working in all the In-patient units and the Emergency departments of two public and two private healthcare settings in Karachi, Pakistan. The study also included nurses working in various management positions; such as Head Nurses, Clinical Nurse Instructors, Nurse Managers, and Nursing Superintendents.

Sample Size
The sample size is based on recent studies examining workplace violence. The reported prevalence of physical and psychological violence among nurses ranges between 3% and 98% (AbuAlrub et al., 2007; Jackson & Ashley, 2005; Kamchuchant et al., 2008; Kwok et al., 2006). The recruited sample was 143 nurses from AKUH, 147 nurses from LNH, 83 nurses from Abbasi Shaheed Hospital, and 85 nurses from the Civil Hospital, respectively. All together 458 nurses were recruited for the study.

Sampling Strategy
A simple random sampling method was used for the study.

Data Collection, Entry and Analysis
After receiving approval from the Aga Khan University's Ethics Review Committee (AKU, ERC), the data collection process was started. The instrument used to collect the data was *"workplace violence in the health sector country case studies research instrument"* This tool was prepared by International Labour Office (ILO), International Council of Nurses (ICN), World Health Organization (WHO), and Public Services International (PSI). The data was entered in the Epi info version 3.5.1. Later, the data was entered by using the Statistical Package for Social Sciences (SPSS) version 19. Descriptive and inferential analyses were carried out to achieve the purpose of the study.

Study Results and Discussion

Demographic and Professional Characteristics of the Study Participants
Out of the 458 nurses who participated in the study, 37.3% (n=171) nurses were working in the government healthcare settings and 62.7% (n=287) nurses were working in the private healthcare settings. In the government healthcare settings, 65 % nurses (n=111/171) were 35 years of age or above. However, around 77% (n=221/287) nurses working in the private healthcare settings were younger, falling between the ages of 19 to 29 years. The gender ratio was found to be predominantly female, as 75.8% (n= 347/458) nurses in the sample were females; whereas, only 24.2% (n= 111/458) nurses were males.

Overall, 88.2% (n=404/458) nurses were working as Nursing Interns or Staff Nurses at both the private and the government healthcare settings. On the other hand, only 11.8% nurses were working at various management positions such as Head Nurse, Supervisor, Manager, and Chief Nursing Superintendent. Overall, 54.5% (n=250/458) of the nurses had between less than a year to five years of work experience. A majority of the nurses (78.8% n=361/458) were working in shift duties. Altogether 35.4% (n= 162/458) of the nurses were working in the Medical Surgical areas, 20.5% (n= 94/458) in the Intensive Care Units (ICU), 23.1% (n= 106/458) in Specialized units, which include Pediatrics, Neurology, Oncology, and Orthopedics while 10.5% (n= 48/458) of the nurses were working in the Emergency departments. Similarly, 2.8% (n= 13/458) of the nurses were working in the Psychiatric units and 5.9% nurses were working in the Obstetrics and Gynecology units.

Study Questions: Prevalence of Physical and Psychological Workplace Violence
The current study reported an 82% prevalence of workplace violence towards nurses working in the government and private healthcare settings of Pakistan. The reported prevalence of workplace violence in the government and private healthcare settings was almost similar, that is 80% in the government healthcare settings and 84% in the private health care settings. Prevalence of workplace violence was found to be less than the reported prevalence of workplace violence in Iraq which was 91% among a sample of 116 nurses (AbuAlRub et al., 2007). The high prevalence of workplace violence in Iraq was attributed to war conditions that have damaged the healthcare system within the country and have significantly increased the nurse patient ratio. Similarly, in Pakistan though there is no war situation, the geo-political situation causes frequent terrorist acts which could be contributing factors towards the high stress levels among the patients and their healthcare providers. A substantial amount of literature reveals that the high stress levels of patients and their relatives is a primary determinant of workplace violence at healthcare settings (Farrell et al., 2006; Lin & Liu, 2005).

The prevalence of workplace violence in the current study is much higher than what is reported in various countries. The estimated prevalence of workplace violence towards nurses in Taiwan was 62% (Lin & Liu, 2005), Hong Kong 76% (Kwak et al., 2006), and in Australia it was 73.5% (Mayhew & Chappell, 2003). Findings from a study in Hong Kong found that the traditional hierarchical status of men in the Chinese society makes female nurses more vulnerable to workplace violence (Kwak et al., 2006). Similarly, in the Pakistani society also, males consider themselves superior to females. Other reported reasons for the high prevalence of workplace violence in the Pakistani context could be because of the low image of the nursing profession in Pakistan, less training opportunities for nurses to deal with violence, over burdened nursing staff, and the nurses' perception that violence is a part of their profession (Lee & Saeed, 2001). The significant reason for the high prevalence of workplace violence at private healthcare sectors can partially be explained by this fact that people from upper socio-economic class usually prefer private hospitals for the treatment. They come with high expectations from the organization as they pay for the treatment in high amount. Any delay in nursing care or

treatment ends up in violence towards care providers. In addition, it is likely that for elite class, nursing is a low profile job. Therefore, exhibiting any kind of abuse or disrespect towards nurses may be considered as an acceptable phenomenon. In addition, nurses working at the private healthcare settings are probably more aware of different kinds of workplace violence as well as felt support of senior management as compare to the nurses working at the government healthcare settings; this may be one of the reasons for increase reporting of workplace violence at private healthcare settings. Moreover, at the government healthcare settings student nurses were mostly involved in direct patient care. The incidents of violence experienced by the student nurses were not the part of this study.

Prevalence of Physical and Psychological Workplace Violence

Physical Violence

Literature reports controversial findings with regard to physical violence towards nurses. The findings of the current study highlight that overall 16.4% of the nurses had experienced physical violence in the preceding twelve months at their workplace. The reported prevalence of workplace violence in the private healthcare settings was 17%, which was higher as compared to the government healthcare settings, where the reported prevalence of physical violence was 15%. The mentioned prevalence of physical violence in the private and government healthcare settings is less when compared to that in various countries. In Iraq the reported prevalence for physical violence was 42.2% (AbuAlrub et al., 2007) and in Hong Kong, where 420 nurses had participated in the study it was18%, (Kwak et al., 2006). In both Iraq and Hong Kong the authors had used the same questionnaire which was used in this study. In Turkey a 19.7% prevalence of physical violence was reported. Altogether, 66 nurses from four major hospitals had filled a 34 item questionnaire (Ergun & Karadakovan, 2005). In Australia the reported prevalence of physical violence was 64% (Farrell et al., 2006). In Iran a 31.4% prevalence of physical violence was reported (Shoghi et al., 2008). Studies conducted in Iraq and Iran mention that the absence of policies and political instability may contribute towards the high prevalence of workplace violence (AbuAlrub et al., 2007; Shoghi et al., 2008).

In various other countries, the prevalence of physical violence is seen to be comparatively lower than what was found in this study. (Kuwait 7%, Adib et al., 2001; Jamaica 8%, Jackson & Ashley, 2005; Taiwan 12.7%, Lin & Liu, 2005; United Kingdom 5%, Wells & Bowers, 2002). The reasons for the low prevalence of physical violence could be their well developed healthcare delivery systems, structured reporting mechanisms, good communication skills of nurses with their patients, and timely accomplishment of the patients' needs by the nurses. On the contrary, Pakistan is considered to be a developing country in Asia; hence, the overall healthcare delivery system is not well established or developed yet. Moreover, there is a shortage of nurses in almost all hospitals. It is possible that the mentioned prevalence of physical violence in the current study could be because of the nursing staff being over burdened, their frontline position with stressed people, and the low image of nurses and the nursing profession in the Pakistani society. In the current study, overall, 63% of the nurses had witnessed physical violence in the last twelve months. The mentioned prevalence reveals the extent of the issue of physical violence in both the government and the private healthcare settings in Pakistan.

Prevalence of Psychological Violence

Verbal abuse. The reported prevalence of verbal abuse in the current study was 77%. The prevalence of verbal abuse was also high in the private healthcare settings (79%), as compared to the government healthcare settings (74%). The mentioned prevalence of verbal abuse exceeds the reported prevalence of verbal abuse in Kuwait (48%, Adib et al., 2001), Australia (64%, Farrell et al., 2006), Minnesota (34%, Gerberich et al., 2004), Jamaica (39%, Jackson & Ashley, 2005), Hong Kong (73%, Kwak et al., 2006), Taiwan (63%, Chen, Sun, Lan, & Chiu, 2009), and Brazil (39.5%, Palacios et al., 2003). However, the prevalence measured in the present study has been found to be comparatively less than the prevalence of verbal abuse measured in Iran, which was 87% (Shoghi et al., 2008). Significant contributing factors of verbal abuse mentioned in the literature include long working hours of nurses, their inability to fulfill the needs of the patients, overcrowding within the hospitals, a blaming attitude within the organization, long waiting time by patients to receive treatment, and over stressed patients because of their impaired physical health. In addition, a majority of the nurses assume that verbal abuse is to be in the nursing profession. Therefore, most incidents of verbal abuse experienced by patients and their relatives are underreported (Jackson & Ashley, 2005; Kwak et al., 2006; Lin & Liu, 2005; Shoghi et al., 2008). In my view, the high prevalence of verbal abuse in the private and government healthcare settings of Pakistan could be due to the same reasons as mentioned in the literature. On the other hand, the prevalence of verbal abuse in Kuwait is relatively low as the nurses believe that disrespect towards them must be reported so that appropriate measures could be taken to combat the issue (Adib et al., 2001).

Bullying/ mobbing behavior

The prevalence of bullying/ mobbing behavior mentioned in the current study was 33.8%. The reported prevalence of bullying/ mobbing behavior in the government healthcare settings was 35% and in the private healthcare settings it was 33%. The reported prevalence of bullying/ mobbing behavior in Pakistan is relatively high compared to various other studies (Jamaica 12.4%, Jackson & Ashley, 2005; Australia 10.5%, Mayhew & Chappell, 2003; Brazil 18.5% public and 17.9% private healthcare sectors, Palacios et al., 2003). In New Zealand it has been found that 16% of the nurses faced emotional neglect, 31% reported to be undervalued by management staff, 17% felt their learning opportunities had been blocked, 16% felt distressed because of workplace conflict, and 23% reported being over burdened without getting appropriate support (Mckenna et al., 2002).

The findings of the current study correlate with the study conducted in Hong Kong where the reported prevalence of bullying/ mobbing was 45% and staff members, colleagues, and supervisors were the main perpetrators of workplace bullying (Kwak et al., 2006). The mentioned research studies highlighted that lack of competency in novice nurses in performing patient care was the major cause of workplace bullying towards nurses. This may relate to healthcare settings of the current study also, as the proportion of novice nurses was considerably high as compared to the senior nurses. Novice nurses usually have less expertise in performing patient care and in dealing with critical situations. Moreover, in nursing divisions nurse managers and supervisors consider themselves accountable for the overall ward management. It is quite usual for them to exhibit lateral violence towards nurses which includes, be rude and abusive in behavior, unjust in criticism, and to pass teasing remarks towards nurses. Hence, nurse managers and supervisors might not consider it as workplace bullying, as, for them, it could be part of their job responsibility to make nurses more competent in providing quality patient care. Moreover, workplace values and policies define the overall culture of the organization (Cowie, Naylo, River, Smith, & Pereira, 2002). Therefore, it is likely that in the government healthcare settings of Pakistan, the high prevalence of bullying/ mobbing behavior could be because of the traditional hierarchical system, where senior nurses exhibit bullying attitudes towards junior nurses (Lee & Saeed, 2001).

Sexual abuse. The reported prevalence of sexual abuse for the current study was 10%. The reported prevalence of sexual abuse in the government healthcare settings was 11.7 % and in the private settings it was 9%. The findings are relatively low in comparison with international studies, such as, in Israel it was 90% (Bronner et al., 2002), in Turkey 37% (Click & Click, 2007), and in Hong Kong 12% (Kwak et al., 2006). The low prevalence of sexual abuse in the mentioned study as compare to the above mentioned studies may be due to under reporting of findings secondary to shame and guilt associated with such incidents. However, the prevalence of sexual abuse in some countries was lower as compared to the data found in this study, such as in Thailand (0.7%). In Thailand the low prevalence of sexual abuse could be because of the better image of nursing, where it is considered a respectable profession. Secondly, it has been mentioned by authors in the article that the hospitals that they had chosen for the study had structured training facilities for nurses to provide quality care to patients and to prevent violence against them. In addition, the influence of media also contributes significantly as in Thailand, usually, the media uncovers the incidents of violence towards nurses for the general public (Kamchuchat et al., 2008).

It is likely that the mentioned prevalence of sexual abuse found in this study could be because of the negative image nurses have in the society, the lack of training facilities for them in how to deal with sexual harassment, the lack of security measures taken to prevent sexual violence prevention, and a feeling of guilt associated with experience of sexual harassment. Though, media in Pakistan does highlight the pathetic cases of workplace violence, it also portrays a negative image of nurses in the society (Lee & Saeed, 2001). Lastly, the high influx of patients and overcrowding in the healthcare settings make nurses more vulnerable to sexual abuse (Kwak et al., 2006).

Conclusion

This study attempted to identify the prevalence and characteristics of physical and psychological workplace violence experienced by nurses working in two private and two government healthcare settings in Karachi, Pakistan. This study is probably the first study in Pakistan which explored the prevalence of almost all kinds of violence towards nurses. The reported prevalence of workplace violence, overall, was 82%. The prevalence of workplace violence in private healthcare settings was higher (83.6%) as compared to that found in the government healthcare settings (79.5%). Young female nurses who work at the patients' bedside in shift duties were more frequently victims of both the physical and psychological violence mostly by patients and their relatives. The frequency of violence was found to be the highest in the Medical Surgical units, Intensive Care units, and Psychiatric and Emergency Departments. Workplace violence contributes towards various physical and psychological consequences for nurses working in any healthcare organization. However, a majority of the nurses had not reported the incidents as they had the perception that nothing could be done against the abusers nor could they prevent it in healthcare settings.

The present study attempted to identify the extent of workplace violence towards nurses in the healthcare settings of Pakistan, which has not been studied before in the same context. This study could be a milestone towards the implementation of *"Harassment of Women at Workplace, Act 2010"* and would help to achieve one of the goals of the World Health Organization (WHO), that is, a violence free healthcare environment. Eventually, a violence free healthcare environment would bring better health outcomes and better quality nursing care to patients

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Learning objectives

1. To demonstrate the magnitude of workplace violence towards nurses in developing countries like Pakistan.
2. To demonstrate evidence based strategies to develop violence free healthcare organizations.

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The violence of waiting rooms: How medical waiting rooms cause harm and prevent healing

Paper

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Focus: Education and Training
Keywords: Medicine, violence, structural violence, waiting room, art, video games

The dingy, yellowish-brown waiting room is crowded with ugly vinyl chairs of a 70s orange hue and arms of blonde wood. I am relieved that only four chairs are occupied in the cramped and claustrophobic space. The television emits piercing screams and shouts as someone on a game show wins a car. Through a small window, a receptionist is barely visible to the room of angry and unsettled patients. I am told that in a few minutes I will be taken back for an x-ray and to have a seat. I sit with a thud in a chair that deceives me with its cushion-shaped seat of hard foam. Fifteen minutes pass as I awkwardly shift my weight in a perpetual quest to ease the incessant throbbing of my ankle. After another five minutes I hobble to the window and peer into a spacious room at a receptionist sitting in a soft office chair. Her eyes stay locked on her computer screen as she asks me what I need. Careful to not appear angry or upset I ask if it will be much longer before I get my x-ray, letting her know I have a meeting in forty-five minutes, at twelve-fifteen, that I cannot miss. Without looking up, she tells me that it will be a few minutes and to have a seat until they call my name. Fifteen minutes pass and I feel a slight tightening in my chest and stomach as I repeatedly check the time, watching the hands move closer to the time of my meeting. I rise and limp carefully to the window. This time she looks up as I tell her that I have never gotten an x-ray before and ask how long will it take in order to determine if it is worth waiting. She ignores my question and tells me that in a few more minutes they will call my name to take me back. Fifteen minutes pass as my anxiety continues to increase as I calculate the growing impossibility of getting to my meeting on time. I feel my eyes burn with hot, angry tears that threaten to spill down my flushed cheeks at any moment. My hands remain tightly clasped in my lap to hide their now uncontrollable shaking as I work to compose myself in preparation to approach the window once last time before leaving. I walk to the window and ask her to verify that my insurance has not been billed yet for the x-ray because I need to leave. Without looking up to see tears now rolling down my cheeks she tells me that they are looking for the x-ray technician and that it will just be a few more minutes. My voice wavers, getting slightly shrill as I repeat that I need to make sure my insurance has not been billed because I have to leave. She now looks up telling me it has not been billed and a look of surprise fills her face as finally becomes aware of my agitation. I leave the office faltering as I walk on a possibly broken ankle with angry tears streaming from my eyes, my chest heaving with short and uneven bursts of air.

The waiting room functions as a space of initial interaction between patients and the health care system, but it is often a place of anxiety and frustration for those individuals seeking care and treatment for illness and injury. Although the waiting room is generally a place of irritation and annoyance, it also often becomes a place of violence. The structure of the waiting room routinely facilitates violent experiences for patients. The account above is of my own experience in a medical waiting room when seeking treatment for a possibly broken ankle. By incorporating personal experience along with structural analysis, my goal is to link theory to practice. Using a theoretical approach, this essay examines the specific conditions that lend themselves to cause and perpetuate the violence enacted by the structure of the medical waiting room. I will also offer solutions that call for the incorporation of artistic means to health care education that to help prevent providers from unknowingly enacting violence against patients.

The violence experienced by patients in medical waiting rooms is the indirect, covert and quiet violence. Although covert violence *"does not involve direct physical assault on anybody's person or property"* (Garver, 1968, 245) it does cause harm nonetheless. The medical waiting room can be a place of harm for patients because of the institutionalized or structural violence of this setting. According to Paul Farmer, structural violence is suffering that is *"'structured' by historically given (and often economically driven) processes and forces that conspire- whether through routine, ritual, or, as is more commonly the case, the hard surfaces of life- to constrain agency"* (Farmer, 2005). This institutionalized violence is one that is perpetuated by the ideological structure of medical system. The medical waiting room is structured in such a way that it works to oppress patients.

Although the waiting room is not a site of treatment for patients, it still functions within the larger structure of the medical system; a power structure that mimics that of the larger health care system in which it operates. The structure of the medical system is rooted in a mechanistic model of treatment and healing. Health care workers' actions are constrained in the waiting room setting because of the larger biomedical model that the waiting room functions within. This model reduces patients to their biology, because it subscribes to the idea that people have biological problems that need to be fixed (Feuerstein, 1986). The biomedical model positions patients as objects that need fixing and requires that patients (human beings) respond to commands in a mechanical way. Patients are objectified when they are positioned as objects that need fixing. Dehumanization occurs when an individual is objectified which often results in a denial of their subjectivity.

This dehumanization can be identified in multiple ways in the example with which this essay began. In this scenario, both structural and relational forces dehumanize and other the patient. The physical separation of the

patients and the receptionists is like the physical separation of animals and humans at an aquarium. A physical barrier that emphasizes that difference protects the spectators and animals from one another. The same is true of the waiting room that isolates the clean, spacious reception area from the dingy and overcrowded patient waiting area. Waiting rooms often vary in appearance, structure, and layout based on the population they serve. The waiting room described at the beginning of this paper is one that caters a lower socio-economic clientele. This is important to note because the physical structure of the waiting room varies based on the income of the patients.

The hierarchical structure is another way that the medical waiting room causes violence against patients. The receptionist is situated in a position of authority as a result of the hierarchy of the health care model. Dehumanization of the patients can occur as a result of the power structure that is present between the receptionist and the patient. The patient is dependent upon the receptionist because the receptionist acts as a gatekeeper controlling access to the receipt of treatment. The receptionist does not have to recognize the patient's subjectivity because he or she is in a position of power over the patient. Patients suffer a loss of their humanity when their subjectivity is not acknowledged (cf. Benjamin, 1988). The receptionist is complicit in supporting that hierarchy when he/she exercises her power over the patient by controlling the information he/she allows the patient to receive and also when active listening does not occur.

A particular problem that arises with the mechanistic model is that objects that just need to be fixed do not need to be heard. The inability of providers to hear patients is apparent in the experience described above when the health worker did not hear and respond to the patient's question. In the waiting room setting, the failure on the part of the receptionist to actively listen to patients is a way in which patients' voices are denied. Feelings of helplessness and fear in the patient are often exacerbated because of a denial of voice in these interactions. The failure to listen becomes a denial of another's voice because it is a failure to validate that voice. The interaction described at the beginning of this essay exemplifies how a failure to listen causes a lack of recognition. Information was requested (how long the x-ray will take) but this request is ignored. This type of failure to communicate can cause patients to not only feel helpless but also invisible, because there is a denial of voice. The patient's request for information is not acknowledged and therefore it is like it does not exist. This denial of voice functions as a lack of recognition of the patient's humanity and therefore prevents a connection from being possible. This is especially harmful to patients, because *"the core experiences of psychological trauma are disempowerment and disconnection from others"* (Herman, 1992). The denial of voice often experienced by patients in the waiting room sets the stage for the kind of interactions a patient can expect with the health care system.

Health care workers often fail to engage patients in conversations that are rooted in mutual respect, and this failure can result in the patient losing his or her sense of self. This is often the result of health care workers failure to listen to patients and this reinforces the dehumanization of patients in this health care exchange. The failure of health professionals to listen to patients is especially detrimental because the medical waiting room is the first interaction patients have with this system. It is in this space that trust or distrust begins to be built. *"Through verbal and nonverbal behaviors, including silence, health care participants coordinate their actions and affirm or negate preferences for identity, relational roles, and course of health care treatment"* (Beck, 2005). Health worker interactions with patients impact patients' ability to trust the medical system, which creates problems because this is a system that is dependent upon the trust of patients to best function. Patients are required to trust the professional judgment of practitioners and this trust gets called into question when patients experience dehumanization.

Another form of violence that is pervasive in the medical waiting room is violent communication, and often there is a lack of understanding of the ways that communication can become violent. Communication becomes violent when it fails to clarify and does not address the needs or requests of all the individuals involved in the communication (Rosenberg, 1999). It is extremely unlikely that the receptionist had the intent to cause harm to this patient through her manner of communication, but by communicating an ambiguous time that does not correspond with reality she is not being clear with the patient. Although the phrase *"a few minutes"* transfers no useful information to the patient about how long it will actually take, it does transmit information of the value and role assigned to the patient. By communicating non-information to the patient, the receptionist was actually communicating that it is not necessary for the patient to receive this knowledge. By failing to communicate useful information, the receptionist reiterated the patient's role as the object of the health care system, denying her subjectivity.

Although the violence inflicted on patients in the medical waiting room is generally not intentional, health care workers are nonetheless still participants. Because this violence is not the result of clear intent, acknowledging and eradicating it proves to be a difficult task. Utilizing art as a tool for understanding the covert violence present in the medical waiting room could prevent health care workers from being unknowing participants. There are many different types of art and of these various types there are ones that lend themselves well to educating those in health care of the covert violence enacted on patients in this setting. One such art form that could be a powerful tool for educating patients is video games. The medical profession is already using video games to teach practitioners to identify and respond to problem patients such as individuals seeking narcotics (Johnson, 2012), but they also have the potential to teach practitioners to identify and respond to the problems of the system in which they work. Dr Pippin Barr is a video game scholar who has created a game that is all about waiting- *"The Artist is Present"* (http://www.pippinbarr.com, 2011). The game, based on Marina Abramovic's performance art piece of the same name, is one that is enables the experiential teaching of the antagonism of waiting. Players are required to wait for the museum to open and then wait in line for their turn to see the artist, Abramovic. Players must actively pay attention to the game in order to ensure they progress their player when the line shifts. Playing this game evokes the feeling of tedious anxiety. Players are required to

pay attention to this boring task with no anticipated end, and a failure to pay attention results in losing one's place in line.

www.pippinbarr.com/games/theartistispresent/TheArtistIsPresent.html

While this game is not specifically designed to emulate the experience of the medical waiting room it does elicit the anxiety associated with waiting in such a setting. Utilizing video game theory to design games specifically for teaching understanding of patient experience has the potential to enable experiential learning for practitioners. It is through experiential learning techniques that health care providers can better understand the way they impact the patient's experience seeking medical care.

Within the setting of the health care system, practitioners' actions are informed by the structure in which they operate. The medical waiting room is the gateway into treatment, but this gateway often functions as a site of violence. The harm done to patients through these practices causes compromised care and inhibits healing outcomes for patients. In order to eliminate the violence of waiting rooms the institutional violence embedded in the health care system must be addressed. Until this occurs, the patients will continue to experience harm and this will cause healing to be impossible. Educational and training solutions that utilize art are necessary in order to prevent the violence of medical waiting rooms and the harm it causes patients.

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Learning objectives

1. To reveal the ways that covert and quiet violence is often present in the waiting room setting.
2. To demonstrate artistic approaches to education of practitioners and framing of interactions can help alleviate that violence.

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Chapter 6 - Horizontal/ lateral aggression/violence, like bullying, mobbing and intimidation

Lateral violence in nursing: The experience in two urban hospitals in Jamaica

Paper

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Focus: Practice
Keywords: Lateral violence, interpersonal conflict, disruptive behaviour, job satisfaction, bullying

Introduction and background

In Jamaica, the phenomenon of lateral violence and bullying is not recognised or addressed, for a number of reasons including the perception that this behaviour is a normal rite of passage. A new or novice nurse in Jamaica consistently expects the worse patient allocation, and 'bad treatment' from more experienced peers. Lateral violence has attained a level of normalcy despite being much complained about, and runs parallel to expressions of fear and anxiety, not only from the treatment experienced, but also that fear which stems from the lack of confidence and distrust in those responsible for addressing the problem. Jackson & Ashley (2005) identified workplace violence and work related stress are significant issues with nurses in Jamaican hospitals. Coupled with the high incidences of community violence, lateral violence, as a type of workplace violence, places the nurse under extreme psychological and physical pressure with wide ranging sequelae at both a personal and institutional level.

The first step to addressing a situation that has been accepted as 'normal' by the group is to bring the problem out into the open. Definitive action must be taken to address the problem of lateral violence and its impact on both nurses and patients. Training and empowerment to deal with the situation is crucial

Methodology

A qualitative study design was employed. A sample of 16 registered nurses, midwives, nurse managers and enrolled assistant nurses from all major service areas (Medical-Surgical wards, Obstetrics & Gynaecology, Paediatrics, Accident & Emergency Department, Orthopaedics and the Operating Theatre) were recruited from two major hospitals in Kingston for two focus group discussions. Nurses were selected based only on their availability at the time. The focus group discussions lasted approximately 60 minutes each, and were held at each institution. The eight (8) participants in each group were informed of the objectives of the focus group discussions and were advised that they were free to refuse participation if they wished, without any adverse repercussions. Oral informed consent was gained, and privacy and confidentiality assured: no personal or identifying information would be disclosed; and the risks and benefits of the study described. Four (4) key informant interviews were also held with staff development and nursing administrative personnel in both institutions. All discussions were audio-taped and transcribed. Thematic analyses of the data were done after a coding framework was established based on the emerging themes identified from the words of the participants. A set of codes based upon concepts identified in the literature was used as a starting point.

Lateral violence was described to include the overt and covert behavioral characteristics described in the literature: negative non-verbal innuendos (eg. raising eyebrows, making faces); verbal affronts (with-holding information, snide remarks); undermining clinical activity (unavailable to help, refusing to help); sabotage; bickering; scapegoating; backstabbing; gossiping; and broken confidences (Alspach, 2007; Griffin, 2004).

The University Hospital of the West Indies is the premier 550 bed teaching hospital in the Caribbean, offering specialized and tertiary health care services locally and regionally. It is also the major research center in the

Caribbean. The Kingston Public hospital is a multidisciplinary adult care hospital with a bed capacity of 500. This 200 year old public health facility is located at North Street, in the heart of Kingston, Jamaica. The KPH is the referral institution for other public hospitals and health agencies in the island.

This study formed part of a larger study on Violence Prevention in the Health Sector and gained ethical approval from UWI/UHWI/FMS Ethics Committee, as well as individual institutional permission. Data were collected over 2 days

Findings

The sample included females only with an average nursing experience of 5 years (range 4 months – 25 years). 8 main themes arose from the focus group discussions.

Most nurses accepted Lateral Violence as normal and were not aware that the acts constituted workplace violence. Many of the behaviors described in the literature as being characteristic of lateral violence were not recognized as violent behavior by the Jamaican nurses, for example : negative non-verbal innuendos (eg. raising eyebrows, making faces); verbal affronts (with-holding information, snide remarks); undermining clinical activity (unavailable to help, refusing to help); bickering; backstabbing; and gossiping. They expressed concern and surprise that seemingly 'normal' expressions were considered violent: *"I never realized it was violence"* and *"Every single nurse I know went through this!"*. One registered nurse thought her negative experience had to do with where she was coming from (she was previously an enrolled assistant nurse) – some form of intra-professional victimization, *"It's a power struggle. We are not defined as individuals with potential. Even when someone improves themselves, we still see them as where they are coming from"*.

All participants had reportedly experienced and witnessed lateral violence. Persons tried to deal with the situation by avoiding the bully – *"… it was so bad I did not want to work with the person (the bully), I tried my best to avoid working with that person."* The experiences varied with frequency and type, *"It's an everyday experience- for me"*. There may even have been an element of racial discrimination. One nurse who was a non-national said *" I make requests – they are not granted , no reason give; the shouting, treating me like I am an idiot…"*

Many incidents of lateral violence surrounded the issue of disproportionate and unfair patient assignment, *"As a new nurse I have a problem with the patient assignment. I was assigned the most difficult patient for 3 consecutive days, contrary to culture, contrary to what we were told on orientation. But I do not complain, I just do what I have to do."*

There was also a problem with making the schedule of assignment; *"Whenever I made the patient assignment, it was always a problem. She gave me a chance to do the assignment – but found fault with everything I did. It was very frustrating and intimidating"*.

The most common form of violence experienced was verbal abuse

Perpetrators could be peers, subordinates or supervisors. No physical or sexual abuse was disclosed. Some nurses were very specific about the type of verbal abuse they suffered, *"She is negative; saying things… backstabbing, name calling. I have no idea the basis for this"*. Maltreatment by peers was demonstrated with comments from this nurse, *"Instead of nurse talking directly with me about something I had done, she spoke with other nurses; laughed at me and talked behind my back; everyone knew about the incident except me. I felt really bad – persons were talking about me. I avoided her and I have never spoken to that nurse again unless it has something to do directly with the patient"*.

The supervisors aggression was offensive to this nurse who felt she was being treated unfairly, *"The Supervisor told me bluntly I was lying. I was really offended because I was speaking the truth, and there was no precedence for her to come to that conclusion based on my behavior in the past"*. Other comments related to managers and supervisors included being denied opportunities for advancement/selection for courses; ignoring specific requests for time off; being unapproachable or being verbally dismissive; denying permission for premium over-time sessions. (Because of a chronic nursing shortage, many wards rely on staff members working overtime sessions to meet staffing requirements. Premium rates are paid on the week-end and at nights.)

There were also incidences of unprofessional behavior among staff members that could negatively affect the affected nurses' credibility with their patients, *"Nurses badmouth other nurses in the presence of clients and their relatives"*.

Doctors were also guilty of verbal abuse, of speaking in a derogatory manner, many times in public, which affected the nurses' confidence. Even the nurses who were assertive were not speared, because doctors would refuse to speak directly to nurses who query their orders for valid reasons.

Incidents were mostly unreported as victims felt nothing would be done

They felt that unless you were friendly with the supervisor, reports of unprofessional behavior would go un-noticed or ignored. Some nurses resorted to side-stepping official lines of communication to get some problems solved. Participants felt they lacked the support and recognition of their administrative superiors, particularly when issues arose concerning inappropriate behavior of medical personnel. They expressed that the

complaints were more likely to be ignored, because of the doctors' status as a *"great income earner for the hospital"*.

Nurses also did not like the idea of reporting on others, especially if the perpetrator was a manager or senior member of staff. They expressed fear of recrimination or victimization, and were prepared to *"…bear it until…. better comes"*.

New graduates, junior nurses and enrolled assistant nurses experienced more incidences of lateral violence. New, inexperienced nurses and enrolled assistant nurse bore the brunt of lateral violence in both institutions. The new nurses accepted it as rite of passage and thought they had to *"pay their dues, and come up through the ranks, and not complain"*. A certain level of demeaning behavior was expected and tolerated. Although senior nurses were commonly the perpetrators, some junior nurses and Enrolled assistant nurses were perceived as the bullies, and were sometimes perceived as being more aggressive. The issue of the level of certification was a cause for concern. Some senior nurses felt that nurses who had baccalaureate, or graduate degrees or specialty training tended to act in a superior manner to their peers who were less qualified. On the other hand, nurses with undergraduate and graduate degrees felt that *"certificate nurses"* had negative preconceived ideas about the university graduates that were not easily changed.

Interestingly, the experience of lateral violence was generally pervasive across all the service areas represented, was not specifically related to the perceived high stress levels associated with areas like Accident & Emergency or the Operating Theatre.

Lateral violence affects the quality of patient–care offered

Nurses who were victims were often absent from work, off sick, or underperforming. Nurses verbalized that persistent exposure to hostile behaviors and undermining activities takes a toll; nurses lack motivation and underperform, or their self-confidence becomes eroded, and it *"…eventually will fall over on the patient…"* They were selective in the persons they asked for advice or help, or they struggled on their own rather that asking a known perpetrator. Nurses purposefully avoided working with nurses who were known to be perpetrators, knowing fully well they would be repaid in like manner. They were absent without notice even when they were booked for overtime sessions. Some nurses developed physical and emotional illness, and some participants were being treated for stress related conditions directly related to their jobs, resulting in prescribed absences from work, which negatively affected the staffing schedules and patient-care on the affected wards.

The patient's perception about the quality of care offered by some nurses was also affected by the less than professional exchanges in their presence, *"..Patients lose confidence in the staff when we talk badly about our colleagues and they hear."*

Lateral violence affects retention of nurses

Some participants decided to request transfers from the wards on which they were experiencing lateral violence. They spoke of being unable to deal with the gossiping and victimization, and the change in their morale. Some spoke about their love for the profession and the effect that the hostile behavior had on them, as being a motivator to leave the ward. In a worst case scenario, participants knew of persons actually resigned from the hospital, and even left the profession.

Lateral violence placed nurses under psychological stress

Participants were very deeply affected psychologically by the effects of lateral violence and spoke openly about their emotions of anger, frustration fear and pain. One nurse said *"It's like killing me without physically stabbing me."* They expressed that sometimes the anger spilt over into their private lives, affecting their family relationships. There were reports of sleepless nights as they anticipated facing another day at work. Nurses recognized they themselves were caught in the cycle as a perpetrator themselves, *"..It may escalate, may break you – you become socialized to that environment and you yourself become a part of the cycle"*. They felt this behavior was wrong, but that the culture of hostility of the environment facilitated that response. For some participants, the experience became a motivator to work harder. They felt they had to prove they could survive and even excel despite the odds stacked against them, *"It kinda pushed me to work harder…"*

Conclusion

The findings related to lateral violence in two urban Jamaican hospitals demonstrate that the phenomenon is pervasive, and involves intra- and inter- health professional groups. These results correspond with findings reported in other studies (Johnson 2009; Simon, 2008). Stanley et al. (2007) estimates that lateral violence in the nursing workplace ranges from 46–100%. Supervisors, peers and even junior nurses were identified as perpetrators. Subsequent, yet unpublished work, in one of the sampled hospitals identified the prevalence of lateral violence at 71% with nurse managers being the main perpetrators (Morrison-Small, Aiken & Lindo, 2011).

Committed nursing leadership and political will are needed in addition to the willing participation and personal investment in change from all nursing and health care professionals in the Jamaican society to change this culture of violence. Patients, staff and the institutions involved were negatively affected. Manifestations of stress-related mental impairment which ultimately results in sub-optimal performance and poor quality patient care as described by Lambert &, Lambert (2008) were evident in the study participants. The organization will

suffer economically as staff uses more sick time and if there is increased staff turnover, with increased costs for replacement.

The code of silence among the affected nurses reinforces the need for definitive administrative action, and a zero-tolerance approach must be taken, to encourage reporting thereby addressing the preventable problem of Lateral Violence and its impact on nurses, patients and the institutions involved. There is need for policy development at the level of the Ministry of Health to specifically address Lateral Violence in Jamaican health-care settings, to improve job satisfaction and retention.

There may be culturally specific determinants, components and elements that are unique to the Jamaican experience which needs to be explored. Further research is also necessary to quantify the prevalence of lateral violence, and to assess its impact on the quality of care of patients.

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Learning objectives

1. Lateral violence is pervasive in two urban hospitals in Jamaica.
2. Funding for further research is needed to quantify the effects of Lateral Violence on patients, nurses and the organization; and the development of a specific zero-tolerance approach policy to address Lateral Violence in Jamaican health-care settings.

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Etiology of worker-to-worker violence among hospital employees

Paper

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Focus: Research

Abstract

Background and context

A growing body of research indicates that violence between co-workers (Type III) is prevalent in health care environments. However, little is known about the reasons for conflict and violence between co-workers. The aim of this study was to explore the etiology of worker-to-worker violence in a sample of reported workplace incidents.

Methodology

Qualitative analysis of a random sample of 87 Type III incidents reported by employees of a large hospital system between 2008 and 2010. After removal of all personal identifiers, incident reports were sent to researchers by a database analyst. The constant comparison method was used to explore possible reasons for each violent event. One researcher read through each incident description, assigning a code for the identified reason. This was repeated until no new categories emerged. Each incident report was then re-examined to verify the identified categories. A second researcher read the incidents independently. Categories were then discussed and refined until agreement between the researchers was reached.

Findings

Five main categories emerged as reasons for violence between co-workers: Job Duties, Patient Care, Personal Violation, Staffing/Scheduling, and Phone Calls. Violence in these incidents was primarily in the form of verbal conflict, bullying, threats, or unprofessional behavior. Disputes over job duties was the most common reason for violent behavior, and included poor performance; failure to provide required service; failure to do what was required/expected; and dress code issues. Patient Care, the second most common category, included reports stemming from disputes over the responsibility for a patient; medication/treatment method; patient care location; and resistance to instructions on patient care. The Personal Violation category involved incidents where the reasons for violence were of a personal, intimate nature. These included an aggressive response to a co-worker comment; annoyance because of eye contact; argument over personal space violation; vandalizing of private property, and offensive comments regarding ones physical appearance. Staffing/Scheduling issues often concerned aggressive and violent arguments over work responsibilities and scheduling conflicts. Phone Calls were frequently a catalyst for worker-to-worker conflict, including persistent calls to individuals who did not respond, and refusal to provide requested information over the phone.

Implications

These findings suggest that worker-to-worker violence in hospitals is both job-related and purely interpersonal. On several occasions, feeling undermined or belittled by a co-worker was motivation for filing a report. Each of the categories that emerged from this analysis offers the possibility of concrete interventions that can be implemented to mitigate conflicts and aggression between hospital employees.

Leaning objectives

1. Mechanisms for reporting Type III violence enable the investigation of possible catalysts to conflict and aggression between co-workers. Health care organizations that do not have such mechanisms should consider implementing them.
2. The categories identified in this qualitative analysis indicate that the reasons for Type III violence are both job-related and interpersonal, although the most common reasons for violent incidents were related to job duties. Understanding the etiology of Type III violent events is an important first step in establishing interventions to reduce and prevent this type of violence in hospitals.

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Addressing quality of worklife: Examining horizontal workplace bullying behaviors in nursing

Poster

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Focus: Organisational

Abstract

Background

Research suggests that formal and informal institutional workplace structures and processes can create a fertile environment for bullying. Exploration of key organizational antecedents of role ambiguity, role conflict, role overload, and perceptions of nursing supervisor fairness in relation to horizontal workplace bullying among Registered Nurses (RNs) is missing.

Purpose

This study explores the relationships between workplace structures, processes, and bullying among RNs, and examines the construct validity of Hutchinson et al.s (2008) Workplace Bullying Instrument (WBI).

Method

A web-based survey was distributed to 477 RNs employed at a British Columbia hospital.

Data Analysis

Correlations assess relationships among variables of workplace structures, processes, horizontal workplace bullying, and intentions to leave.

Results

Workplace bullying among RNs was multidimensional (i.e., comprising individual and organizational factors) and bullying experiences can be distinguished between workplace structures and processes. The construct validity of WBI was confirmed. Implications for future research and workplace policy are discussed.

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Impact of bullying on patient care, the Target Nurses Perspective: Findings from a phenomenological study

Paper

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Focus: Research

Abstract

Background and content

Bullying is a disruptive behavior that continues to plague workplace environments not exclusive of healthcare institutions. Nurses are a specific professional group that adversely is impacted by violent behaviors such as bullying. Bullying is defined as a range of overt or covert behaviors, perpetrated by the bully often hidden and difficult to prove, aimed at a target through escalating unethical incidents in frequency and intensity, over time making daily work task performance difficult. Bullying encompasses unethically driven communications that are directed towards another persons self-esteem which ultimately can diminish cohesiveness of teamwork. Bullying negatively influence customer satisfaction and threaten quality and safety of patient care. Unprofessional bullying behaviors targeted at peer nurses while they continue to provide care to patients should be better understood especially if direct patient care is compromised.

Nurses have described disruptive behaviors such as peer bullying which may ultimately affect safe patient care. There has been little evidence to support anecdotal statements demonstrative of this potential. There have been no studies to link disruptive behaviors and patient care. Bullying within the profession and its impact on safe practice has not been explored leaving gaps in understanding how the accumulated effect of bullying directly affects patient care provided from the perspective of the targeted nurse. Moreover, there are limited qualitative investigations into the bullying experience. Additionally, there are gaps in understanding how the accumulated effect of bullying directly affects patient care provided from the perspective of the targeted nurse.
Despite acknowledging the presence of bullying within professional nursing empirical evidence is lacking specifically as to how direct patient care is affected. Anecdotal opinions speculate nurses who have been bullied may jeopardize safe patient care. Building on previous research and suppositions, the impact of bullying while at work and its impact on the target nurse who must continue caring for patients, remains largely unexplored thus demands exploration. A systemic literature search did not reveal literature exploring the bullied targets unique perspective of the care he/she is able to provide in a bullying culture. Unprofessional bullying behaviors targeted at peer nurses while they continue to provide care to patients must be understood to impart understanding of the nurses perspective of the experience.

This has implications for the healthcare industry in promoting safe environments for patients as mandated by the Center for American Nurses, the Joint Commission, the Occupational Safety and Health Administration, and Institute of Medicine. In 2008 the US Department of Health and Human Services recommended strategies to create and communicate respectful collegiality in support of safe, high quality patient care. Recognition of disruptive behaviors and bullying hospital environments has been identified as a significant concern, by each of the aforementioned institutions through their position statements and directives. The aim of this presentation is to impart relevant findings from a study that explored the target nurses perception of how patient care is influenced as a result of being bullied. The goal of this qualitative research was to understand aspects of caring provided for patients by bullied nurses.

Methodology

Utilizing a qualitative hermeneutic descriptive phenomenology design for this particular investigative inquiry, a quality of the experience previously lacking in living knowledge for nursing practice was depicted. Subjective data delineating experience from the target nurses unique perspective of occupational bullying imparted descriptive narratives which enriched understanding of the effects bullying has on a nurse while caring for patients. Qualitative data collection was obtained through one informal interview session with each participant. Using a phenomenological perspective, semi-structured interviews were conducted with nurses who self-identified as targets of nurse-to-nurse bullying. The interview session was held within one month of the participants self-identification to the researcher. This allowed the participant opportunity to contemplate privately on their lived experience, prior to sharing their reflection with the researcher during the interview process. The interview allowed the participant opportunity to elaborate on their lived events. Complete audio-recordings of the interview were transcribed verbatim into text by an independent transcriptionist. Transcriptions were compared with audio-recordings to ensure accuracy. The text generated from each face to face interview was the source data material for this phenomenological investigation.

One interview session of less than 3 hours was agreed upon with each participant for their research time commitment. Anonymity and confidentiality were of particular importance for this study. A private meeting at a

mutually agreed upon neutral site, at a pre-determined date and time was arranged. No interviews were conducted with participants at their workplace. Participants were assured their information collected would be de-identified after the interview process. Pseudonyms were used for the writings of this research process. The single interview was guided by a semi-structured interview format, which facilitated the researchers engagement with each participant. Data were extrapolated from textual transcripts and loaded into a Microsoft Excel spreadsheet. The researcher inductively developed codes which highlighted statements from the transcription particularly essential to participants experience. The highlighted themes were contextualized onto a Word document from each participant.

Phenomenology was used for this study as it focuses on revealing cognitive and non-cognitive meaning which can enrich understanding of an experience.

Dr. Max van Manen's methodological approach, aided in capturing (1) the social processes and context in which nurses who are bullied work and (2) the subjective perspective of the nurses experience. Insight into the phenomenological grasp of the participants bullied stories was grounded from the text within the framework of van Manen's four life existential domains lived space, lived body, lived time and lived human relation.

Findings

Results of this qualitative hermeneutic descriptive phenomenological study were analyzed from data comprised from 5 participants. The summed individual engagements generated 10.5 hours of face to face contact, 9 hours of audio recordings, resulting in 162 pages of transcriptions for analysis. The analysis results identified a common desire amongst each of the participants in promoting and safeguarding the patients they cared for. This finding reflects a disparity from anecdotal evidence in print. Although the participants acknowledged patient care may be jeopardized, each of them adamantly concur the care they were able to provide their patients was reflectant of ethical moral nursing practice, despite the oppressive workplace bully. This finding does not aspire to generalize universality; rather offer recognition of the human experience which may be a globally shared target nurse phenomenon.

The nurse participants shared descriptions of their perspective and recommendations for addressing disruptive behaviors at work such as bullying. Guidance by van Manens methodology uncovered three incidental themes: (a) feelings of being oppressed, (b) feelings of voiceless isolation and (c) feelings of confidence with self to persevere. Two essential themes also noted were (a) patient respect and (b) sense of duty.
In every interview the participants shared stories depicting elements of oppressive acts they encountered at work. Bystanders were present for several incidents. During shift report, while the nurses station was full of activity participants revealed being yelled at, challenged in front of others, being laughed at and ignored. The oppressive acts were both overt and covert. Overt oppression was experienced by the participant from the perpetrator and in some cases higher managerial personnel within the organization as well. Oppressed people assume postures of inferiority. That inferiority segregates the oppressed from the communality of fundamental support within their environment. Participants shared periods while at work of voiceless isolation. The target nurse participants had shared corporality in their circumstance. Each participant shared their stories, as means to break away from their target status. They each felt validated in their role of being a target by the sheer ability to express themselves.

Protective acts within a caring environment were promoted by the participant nurses through respect of their patients. This was consistent with each of the nurses core professionalism. Each of the participants had encounters while at work with bullying perpetrators yet choose to perform their jobs with professionalism for the patients greater good rather than self trepidation. This is not to say, each participant continued patient tasks at hand without qualm, rather each was able to compartmentalize the bullied experience without it negatively impacting their nursing practice and patient care. These acts protected the patients entrusted to the nurses.
Sense of duty in the profession is a general motive which spurs ones performance based on ethical moral guidelines, generating compassion with obligation to do right by ones patient encounters. Each participant performed their nursing tasks, from an intuitive posture of knowing what was ethically required in the course of their day. In the midst of their individual downtrodden positions they were able to rise up and provide safe patient care. Following many of their stories they were asked to embellish aspects of their lived world perspectives; resounding their patient care had not been fraught with unsafe practice. The participants themselves did not impede safe patient care; each encountered situations which were not reflectant of prudent nursing practice. None of the participants in this study felt their nursing practice was negatively influenced as a result of their bullied circumstance.

Implications for practice, research, education & training, organization / management, policy and guidance
Implications for practice include the essential essences described in this study which are important to nurse leaders because their moral agent representations are tenets of nursing practice. Patient respect and sense of duty described by the participants must be embraced to facilitate dialogue in the lecture halls, hallways and boardrooms. Nursing administrators and educators must embrace these two essentials to assist in developing proactive educational programs. These programs must be grounded from understanding central affinity of nurses to safe, effective patient care. In recognizing optimistic essences described herein educational efforts can be devised to advocate for affinity in framing these efforts with enhanced utilization of nursing code of ethics.
Research initiative can target dialogue between colleagues at work would help to resolve an unpleasant incident from becoming a pattern of disruptive and intimidating behaviors. Nursing's Code of Ethics (ANA, 2001)

directs communication as a venue for preserving the integrity of the nurse. Through ethically based communication we can better ensure patient safety. The profession of nursing should require its members to be proactive with each other to facilitate dialogue with current RN staff as well as seasoned RNs. It is a moral imperative to be accountable to ethical conduct, to stay grounded in the course of nursing practice preserving the dignity and worth of our colleagues.

Education and training would be beneficial for nurses to assist each other in dispelling obstruction to communication barriers by empowering each other to speak up. The Code of Ethics for Nurses points each of us towards a principled journey and should be embraced by all levels of the profession. We should hold fast to the directives set forth by our predecessors. This can be accomplished in the classroom, as elements of each syllabus.

Organizational (systems) and management can be proactive by respectful dialogue amongst leaders in the organization and nursing profession with expectations of moral conduct and effective communication being factored in staff meetings, from the bedside to the level of managers and educators. Healthcare organizations are businesses and the face of these business systems are the bedside nurse. These principles of moral respect, conduct and effective communication should be essentials of all levels within the organization system. This must include annual competencies nursing requires in the healthcare environment as well as annual evaluations.

Future policies can evolve from promoting the moral conduct expectations of nursing embraced within the provisions of the Code of Ethics for Nurses. Fostering nurse colleagues in their workplace environment the seasoned nurse contributes to the profession serving in a mentorship role. This helps assure an organizational climate conducive to quality care for the patients nursing serves. Each of the above aforementioned recommendations would diminish disruptive behaviors which targets of bullying encounter. Conjecture would infer stability within our ranks.

Commonality prevailed in the participants dialogue about being bullied and its affect on the care they were able to provide to their patients. The lack of integration of perspectives of both bully perpetrator and target offers a futuristic proposal for study.

- How does the perception of bullying vary between instigators and targets?
- Is the care afforded patients by nurse bully perpetrators similar to the care afforded patients by targets of nursing bullies?
- Would similar data be revealed at differing healthcare institutions?
- Did employment within a Magnet institution align participants to have a voice whereas no nurses self-identified from a non-Magnet institution?
- Would periodic or annual nurse employee morale evaluations provide human resource departments or nursing administration opportunity to spot potential bullying situations?
- Would recognizing the possibility of bullying interrupt it before its forces result in nurses resignation, or worse leaving the profession?
- Are future nurses engaged in the ANA Code of Ethics during each semester of education better prepared to promote collegiality?
- Are nurses educated within an enhanced morality framework better prepared to interrupt disruptive behaviors at work?
- Would employment mentorships of longer durations assist less seasoned nurses from falling prey to instigators?
- Can organizations which require their nurses to adhere to the provisions set forth in the Code of Ethics for Nurses have less attrition?
- How might your work inform similar initiatives in broader health service and/or geographical contexts?

The long term goal of this project is to develop evidence based strategies for implementing ethically based communication orientation programs for academia and healthcare organizations to promote awareness about and to minimize occupational bullying of nurses by nurses. In addition, these programs can be used for continuing education requirements within healthcare and licensing agencies. These programs could be used to promote nursing orientation education for academia and healthcare agencies globally.

Learning objectives

1. Patient respect and protective acts within a caring environment promote nurses respect of their patients which is consistent with nurses core professionalism. Nurses who encounter bullying perpetrators must learn to perform their jobs with professionalism for the patients greater good.
2. Sense of duty in the profession is a general motive which spurs ones performance based on ethical moral guidelines, generating compassion with obligation to do right by ones patient encounters.

These two objectives can be used to develop education and managerial strategies for effective healthcare delivery.

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Bullying behaviours experienced by nursing students: What can be done?

Paper

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Focus: Research
Keywords: Bullying, nursing students, clinical instructors, recommendations

Background

In a profession known for its caring capacity and ethical obligations, it is disturbing to confront the notion that nurses are treating one another with disrespect and disregard. This behaviour jeopardizes the nurse's role as mentor and role model for nursing students. Nurses enter the profession of nursing because of a desire to care for the sick and to assist patients and their families in attaining and maintaining well-being. Student nurses enter the academic world of nursing for those same reasons (Rhéaume, Woodside, Gautreau & DiTommaso, 2003), and yet witness and are subjected to acts of bullying by those same nurses who entered a profession in which caring is the epitome of the practice. Hoel, Giga and Davidson (2007) highlight the significant disappointment felt by nursing students who witnessed indifference, hostility and intimidation by nurses who were purportedly attracted to a profession for its caring nature.

According to a College of Nurses of Ontario (CNO, 2008) report, 4.4% of Ontario's 2007 graduates did not renew their registration in 2008. In addition, the Canadian Institute for Health Information (CIHI, 2007) reported that 6.6% of Canadian RNs under the age of thirty did not maintain their registration for 2007. Although we cannot conclude a causal relationship between exit numbers and experiences of bullying in the workplace, current research has demonstrated that nursing students and new graduate nursing students have either considered leaving the profession or have left as a result of falling victim to bullying behaviours (McKenna, Smith, Poole, & Coverdale,2002).

Canada is expected to be short 60,000 full time equivalent RNs by 2022 (CNA, 2009). Nurses are commonly referred to as the backbone of the health care industry and as such, a shortage of nurses will place a burden on an already encumbered health care system. We must rely on new nurses to fill the shoes of those experienced nurses leaving the workforce as a result of retirement. Student nurses (90%) who have experienced or witnessed bullying behaviours in their clinical placements have reported being adamant about not wanting to work in similar areas upon graduation (Curtis, Bowen & Reid, 2007). All areas of nursing must be free of bullying behaviours in an effort to preserve adequate staffing and patient care well into the future.

Meissner (1986) describes what is happening to young nurses as forms of genocide and cannibalism. Sadly, student nurses expect to be bullied in the clinical setting (Foster, Mackie & Barnett, 2004). Although international studies have demonstrated that nursing students experience bullying during their nursing education, generalizations cannot be made about the rate of incidence in Canada. The purpose of this study was to determine the extent and nature of bullying in nursing education in Canada. In an effort to strengthen nursing as a compassionate and supportive profession, and ensure that we are protecting our colleagues and future nurses, we must first be able to accurately describe the phenomenon of bullying within nursing education. Once this has been identified, policy must be implemented that will eradicate the occurrence of bullying in nursing education.

Method

This descriptive study used a questionnaire to survey nursing students about their experiences of bullying behaviours, reporting practices, demographics, intention to leave the profession, and perceived self-confidence in the clinical setting. A coping inventory was used to assess coping strategies used to deal with bullying behaviours. In addition, a self-esteem questionnaire was used to determine global self-esteem. One moderately sized university was chosen as well as one mid-sized college with two separate campuses and another mid-sized college with one campus.

Results

Of a possible 1167 nursing students, 674 students participated in the study, generating a response rate of 58%. The mean age of participants was 24 years (SD+/- 5.85) and the majority of participants identified themselves as female (83%) and Caucasian (n=522).
Of 674 nursing students, 88.72% (n=598) reported experiencing at least one bullying behaviour. Those students who reported being bullied, according to a single self-labeling bullying item, had higher mean bullying scores (M=25.85, SD=21.05) than those who reported not having been bullied (M=10.51, SD=12.65, $p<.001$).

Among participants who self-reported according to a single self-labeling item that they had never been bullied, (n=486), 85.2% (n=414) had actually identified that they had experienced bullying behaviours according to the

individual bullying behaviours identified in the questionnaire. Among those participants who self- labeled that they had been bullied according to the single self-labeling item, (n=188), only 2.1% (n=4) reported that they had not experienced bullying behaviours according to the individual bullying behaviours identified in the questionnaire (X2 =21.81, p<.001).

Of the 112 male participants, 84.80% (n=95) reported having experienced at least one bullying behaviour. According to the self-labeling item however, only 17% (n=19) considered themselves to have been bullied. Of the 558 female participants, 89.20% (n=498) reported having experienced at least one bullying behaviour. According to the self-labeling item, 30.3% (n=169) considered themselves to have been bullied. Chi Square analysis revealed that females labeled their experiences as bullying significantly more than males (X2=.67, p=.01).

When students were asked whether or not they had witnessed other students being bullied, 48.1% (n=324), reported that they had witnessed others being bullied. Of 674 participants, 41.8% (n=282) reported that they occasionally witnessed others being bullied, 5.5% (n=37) reported that they frequently witnessed others being bullied, and 0.6% (n=4) reported that they witnessed other students being bullied all the time.

Students in the clinical setting most often reported that their efforts were undervalued (60.24%). Of 674 students, 45.25% (n=305) reported being subjected to negative remarks about becoming a nurse, 43.03% (n=290) reported feeling that impossible expectations were set for them, 42.14% (n=284) reported being treated with hostility, 41.84% (n=282) reported being placed under undue pressure to produce work, 41.54% (n=280) reported being frozen out, ignored or excluded and 40.36% (n=272) reported being unjustly criticized.

Student nurses identified clinical instructors as the most frequent source of bullying behavior (30.22%) followed by staff nurses (25.49%), classmates (15%), patients and their families (14%), other hospital staff (8.68%) and preceptors (11.05%). More specifically, clinical instructors were identified to be the greatest perpetrators of undervaluing students' efforts (40.65%), placing undue pressure on student nurses to produce work (35.01%) and setting impossible expectations (33.68%).

Mean total bullying scores were higher (M=29.21, SD=23.86) for those students who had considered leaving the nursing program than for those students who had not considered leaving the nursing program (M=13.11, SD=15.05, p<.001). A significant association was seen between being self-labeled as bullied or not bullied and intentions to leave the nursing program X^2 (1, N = 542) = 83.39, p < 0.001. Among the 88 participants who said they had considered leaving the nursing program, 76.13% (n = 67) reported being bullied according to a self-labeling item. Among the participants who said they had not considered leaving the nursing program (n = 454), only 25.8% (n = 117) had reported being bullied and 74.2% (n = 337) had reported not being bullied.

Of 598 participants, who according to the total bullying score were considered to have been bullied, 22.6% (n=135) reported that they told someone about their bullying experiences. Of 188 students who identified themselves as having been bullied according to the self-labeling item, 52.1% (n=98) reported that they told someone about their experiences of bullying behaviours and 36.7% (n=69) reported that they told no one. Of the 135 student nurses who reported that they told someone of their bullying experiences, clinical instructors (65.19%) and classmates (77.03%) were most frequently identified as confidants. Students also reported telling family members and friends. When the reporting of bullying behaviours was further examined according to sex, it was noted that females were more likely to report incidents of bullying behaviours than males (X2=4.00, p=0.45). Among 143 participants who did not report bullying behaviours, the belief that nothing would be done if the bullying behaviour were to be reported (38.46%) and fear of a poor evaluation (30.07%) were most commonly reported reasons why students did not report their experiences of bullying behaviours.

The data suggest that there is a significant but weak inverse relationship between experiences of bullying behaviours and self-esteem. Those students who had higher mean bullying scores had lower mean self-esteem scores (r=-.198, p<.001). According to the self-labeling item, students who were not bullied had higher mean self-esteem scores (M=33.25, SD= 4.68) than those students who self-labeled themselves as being bullied (M=0.55, SD=4.73, t=6.46, p<.001). According to the overall regression model for self-esteem, staff nurses (sr2 =.007), and clinical instructors (sr2 =.007) and patients/families (sr2 =.010) made significant unique contributions to the prediction of student nurses' self-esteem (R2 =.055, F=12.34, p<.001).
Students answered a baseline question indicating whether or not they felt confident performing most of the skills needed to care for their clients. The data suggest that there is a weak but significant relationship between students' baseline perception of ability to care for their clients and actual bullying behaviours experienced (r=-.082, p=.037).

Discussion

Previous research has revealed that student nurses are the victims of bullying within the clinical setting (Foster et al., 2004; McAdam Cooper, 2007). In this current research 88.72 % of nursing students reported that they had experienced bullying behaviours, with the main perpetrator being clinical instructors. All clinical instructors at the institutions surveyed for the current study, have at minimum a baccalaureate degree, some are masters prepared and a few are doctoral prepared. Although some are educated beyond the undergraduate level, the focus of advanced practice nursing is based on discipline specific knowledge and skills and not on education. Consequently, they are not familiar with principles of teaching learning and since they divide their time among

other part time work, the opportunity for further education on how to be successful as a clinical instructor is limited. While students recognize and appreciate the crucial role that clinical instructors play in their education, they were concerned about the manner in which they were treated (Magnussen & Amundsen, 2003).One student commented that *"After writing in my journal improperly, my clinical teacher told me not to be a nurse."* Another student commented that: *"Sometimes I felt like my clinical teacher would always pick on me. She once asked me 'Do you think nursing is for you?' That was so discouraging."*

Rayner and colleagues (2002) have suggested that those in positions of authority may unintentionally abuse power as a result of lack of preparation in assuming certain duties.
While similar rates of bullying behaviours were experienced by both males and females, males were less likely to identify the behavior as bullying; females were nearly twice as likely as males to identify themselves as having been bullied according to the single self-labeling item. These findings are in contrast to results from a 2005 study of 18,676 Canadian nurses that revealed males were more likely (46.1%) to experience violence than females (33.0%) (Shields &Wilkins, 2005). This discrepancy speaks to the need to further research males' perceptions and reporting practices of experiences with bullying.

Students who experienced more bullying behaviours were more likely to consider leaving the nursing program. This finding is in keeping with other research in which students who have been the victims of academic abuse consider leaving their programs (Celik & Bayraktar, 2004).Students also felt that reporting the incidences of bullying would be of no use since nothing would be done. Unfortunately, this is consistent with research conducted with both nursing students (Stevenson et al., 2006) and with staff nurses (Eggertson, 2011) in which reporting made no impact and in some cases intensified the negative behaviour. It is interesting that in spite of the recent passing of Bill 168 in Ontario, the behaviour continues and its impact is felt across the many levels of the health care sector. Until action is taken to address this behavior, both at the academic and clinical level, the workplace culture will remain unchanged and will continue to destroy the victims as well as the profession as a whole.

Recommendations

We know from the current study that student nurses have identified clinical instructors, who are part of faculty, as the greatest source of bullying behaviours. All faculties, regardless of whether they teach in the clinical setting or not, must receive ongoing education about recognizing, addressing, and reporting behaviours considered to be bullying in nature. We can no longer be a silent witness and allow the behaviour to continue both from an ethical and legal perspective. While policies and procedures may exist that address the issues, unless they are acted upon the behaviour will continue. Systems, such as a tribunal or an academic committee, must be put in place for the victims of bullying to be heard and for action to be taken.

Faculties of nursing must ensure that clinical instructors are equipped with the knowledge and skills to effectively interact with students in the clinical setting. Many institutions have resources to address issues with teaching and learning, whereby faculty have access to workshops, on-line learning, and various resources directed to diverse aspects of teaching, including methods and ways of evaluating students .Conversely, students must be provided with resources related to effective communication skills, coping skills and support for remediation when necessary.

Students also need to know who to turn to when they experience or feel that they are being bullied. The nursing student council can play a pivotal role in setting up a committee, dealing with student complaints which are then brought back to a faculty advisor. An ombudsperson or a designated faculty member should be appointed in this role and students need to know that confidentiality will be maintained.

In conclusion, while numerous strategies may be put in place, the issue of bullying will not stop until each one of us recognizes its existences and refuses to allow the behaviour to occur. We in the profession have allowed this behaviour to occur. We have a moral obligation to advocate for student nurses, address the issue and intervene. The time to stop perpetuating the behaviour is now; if not we are in danger of losing our best and brightest.

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Learning objectives

1. To gain further understanding about bullying behaviours experienced by nursing students in the clinical setting.
2. To identify strategies that clinical instructors can use to prevent the occurrence of bullying within the clinical setting.

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Understanding aggressive events targeting staff members

Poster

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Focus: Research

Abstract

Background and context

Aggression is a serious workplace problem for clinical workers in mental health settings. A study was undertaken to better understand the prevalence and characteristics of aggressive events where staff members were the targets of aggressive behavior. In addition verbal vs. physical events were examined to determine differences by aggression type.

Methodology

The Aggression Exposure Study recorded aggressive events using the Staff Observation of Aggression Scale-Revised (SOAS-R) for a period of 6 weeks on 4 inpatient psychiatric units in an urban hospital in the United States. Information about event provocation, means and target of aggression, consequences and measures to intervene in each event were described. Reports of aggression using the SOAS-R were compared to Standard reports of aggression from restraint and incident reports over the same time period.

Findings

A total of 113 aggressive events were reported over the study period with a prevalence rate of 0.73 aggressive events/20 bed unit/day. This compares to 31 events or a prevalence rate of 0.13 aggressive events/20 bed unit/day if only records of restraint are used. The restraint rate as recorded by the SOAS-R (0.09/20beds/day) is lower than the actual rate of events from required records (0.13/20beds/day), suggesting that rates are underestimates of actual event rates.
A total of 97 events(85.8%) involved verbal aggression, and 49(43.4%) were verbal only events. 64 events were physical acts including 48(75%) involving verbal aggression. 71% of events occurring on the evening shift involved physical aggression and 22% of all events were provoked by a patient being denied something, which was significantly less likely to result in a verbal event (OR=0.18, 95%CI:0.06-0.57). No verbal events involved interventions like parenteral medication or physical restraint, although one involved being held with force.
Aggressive events targeted staff 70.8% of the time (n=80 events), and severity of these events was higher than other targeted events (mean = 10.2 vs. 7.9 (t-02.15, p=0.0335). Staff were more likely the target of events when the provocation was helping a patient with ADL's (n=11 (13.8%) or requiring the patient take a medication (n=11 (13.8%)) (X^2=5.0, p=0.025). Nearly all staff events (90%) involved verbal aggression, and they were more likely to be hit or punched (OR=2.7, 95%CI:1.0-7.3) than other targets. Events with staff targets were less likely to be ended by calmly bringing the patient away (OR=0.35, 95%CI:0.14-0.91. Victims of events with staff targets were more likely to feel threatened (OR=3.4, 95%CI:1.2-9.6) than victims with other targets. However victims of events where staff were targets were less likely to have visible injury (OR=0.14, 95%CI=0.03-0.60) or need treatment (OR=0.12, 95%CI:0.03-0.49).

Implications

Monitoring events using multiple methods offers a better understanding of the nature of events when planning for intervention to reduce patient aggression. Examining the characteristics of events including type and target of aggression can aid in planning interventions to reduce staff exposure to aggression. Regular monitoring of specific characteristics of events using the SOAS-R offers more complete information on the actual continuum of events than measures only involving patient restraint.

Learning objectives

1) To discriminate differences in aggressive events when staff members are the targets of aggression.
2) To better understand the characteristics of events measured by the SOAS-R.

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The Impact of co-worker violence, including bullying, in US Mental Health Facilities

Paper

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Focus: Research
Keywords: Bullying, coworker conflict, impact of bullying, mental health employees

Introduction and background

Workplace violence is an enormous problem worldwide, one that has received increased attention in the U.S. and elsewhere over the past decade (Duhart, 2001; Di Martino, 2002; BLS, 2006; NIOSH 2002; Peek Asa, 2002; Peek Asa, 2009; Lipscomb et al, 2002). A widespread and costly segment of this problem includes those actions which are perpetrated by a current or former fellow employee, so-called Type III violence (UIIPRC, 2001). Type III acts of violence include physical assaults and even homicide, but much more commonly are psychological or emotional in nature. Globally, a range of terms are used to describe Type III violence including: co-worker conflict, workplace incivility, bullying, harassment, mobbing, psychological violence, and emotional abuse (Madangeng, 2009).

A large and expanding literature, led by European researchers in the 1990s, has documented the prevalence of bullying (Einarsen and Skogstad, 1996; Hoel and Cooper, 2000; Hoel et al., 2001; Lutgen-Sandvick et al., 2007), as well as individual and organizational risk factors for those behaviors (Coyne et al., 2000; Einarsen et al., 1994). The prevalence of bullying has been estimated to be between 5% and 30% depending on the way the concept is operationalized and the study methodology (Paoli and Merille, 2001; Zapf et al., 2003).
Some recent studies have begun to document the costs to the individual and organization of these behaviors (Beech and Leather, 2006; Schmidtke, 2011; Madangeng, 2009). These include increased health care expenditures, absenteeism, turnover, and impaired performance (Martin, 2008; Field, 2002; Weinand, 2010; Rändle, 2007; Hesketh, et al 2003; Rosenstein, 2002; Simons, 2008; Lutgen-Sanvik, 2007; Laschinger, et al, 2009; Quine, 1999; McKenna, 2003; Hesketh, et al, 2003; Cook, et al, 2001; Jauregui and Schnall, 2009).

In an attempt to further describe the problem among a diverse population of U.S. state government workers, we conducted a survey in four state agencies. One of those agencies was a state mental health system, where we surveyed staff from three separate multi-service facilities. In 2010 we described preliminary results from that survey, which assessed 6-month prevalence of different manifestations of Type III conflict and violence, including bullying, among employees of state government offices in the Eastern United States (London et al, 2010). This paper describes the impact on the targets of those Type III behaviors and the actions taken by those individuals and their organization.

Methods

Participatory Action Research (PAR) methods were used in the design and implementation of the study. A Project Advisory Group (PAG) that included state government managers and union representatives assisted in identifying agencies that would potentially agree to participate and that, in aggregate, would represent a cross-section of government functions. The PAG also helped ensure that the survey would be understood and well-received by potential respondents, and that it would be administered in a way that would protect respondents' confidentiality and result in a high survey response rate. Virtually all of the surveys were done during work time, and were completed electronically at the University of Maryland-Baltimore's (UMB) secure website.

A battery of six questions selected from among the 22 items of Einarsen's Negative Act Questionnaire (NAQ) was used, as was a standard definition for bullying (Einarsen and Skogstad, 1996). The six questions were selected after the full 22-item NAQ was administered to employees of a pilot agency. The PAG felt that 22 items was too numerous, would take too long to administer, and would likely result in virtually all respondents saying *"yes"* to at least one question. For those reasons, six questions that describe some of the more serious negative acts were selected. The 6-question NAQ demonstrated a good internal reliability, with Cronbach's alpha=0.899 for the overall sample. The six NAQ questions can be paraphrased as: (1) been humiliated or ridiculed; (2) had insulting or offensive remarks made about you; (3) been intimidated with threatening behavior; (4) been ignored or shunned; (5) been subjected to excessive teasing and sarcasm; (6) been shouted at or targeted with spontaneous anger or rage. Bullying was defined as *"abusive behavior (at work) repeated over a period of time and when the victim experiences difficulties in defending him or herself in this situation. It is not bullying if the incident does not occur repeatedly."*

Workers were also asked to provide basic demographic data and information about their work, including bargaining unit, work area, tenure, etc. Care was taken to obtain as much relevant information as possible without it being so specific that individuals could reasonably fear being identified. IRB approval was obtained from UMB.

A total of 12,546 completed surveys were collected from four agencies, including 1,040 from three mental health (MH) facilities. The non-MH agencies performed a variety of government functions, including administrative, regulatory, and maintenance of the state's highway system. A significant minority had some direct contact with the public. At each participating agency, an agency-level PAG was formed to help ensure that the survey would be well-received and to assist in encouraging a high response rate.

The three MH facilities are part of a state-run system of 26 facilities. The system provides a wide range of MH services, including: in-patient adult, both general and forensic; inpatient youth; community residential; and outpatient. The three facilities selected provide all of the above-mentioned services, other than forensic inpatient. They were selected for the survey based on their representativeness, both programmatic as well as geographic, and the interest of the facility managers and union representatives in participating.
The survey was offered to all employees of those three facilities. Those who reported any of the Type III workplace violence behaviors, bullying and/or negative acts, were then asked a series of questions: the position within the organization of the perpetrator(s); actions taken by the respondent; any organizational response; and the impact on the respondent's personal life, work life, and intent to remain on the job.

The responses of those who experienced negative acts or bullying were put into four categories; *"Occasional NAQ"* included those who did not say that they had been bullied but who reported at least one NAQ that occurred occasionally, e.g. less than monthly; *"Regular NAQ"* included those who did not say that they had been bullied but who reported at least one NAQ that occurred at least monthly; *"Some bullying"* included those who said that they had been bullied less than monthly, regardless of their responses to the NAQ questions; and *"Regular bullying"* included those who were regularly bullied, e.g. at least monthly, regardless of their responses to the NAQ questions.

Respondents who reported any of the NAQs or bullying were also asked whether it affected their work (table category *"work"*), whether it impacted their intent to remain in their job (*"remain"*), and whether it had a serious negative impact on their personal life (*"personal"*). For those three impact questions, we utilized a five-point Likert Scale: not at all; not much; somewhat; a lot; and very much. We considered the last two responses as indicating serious impact.

Results

The 1,040 completed surveys represented a response rate of 68.0% among eligible MH workers. A majority, 56.6%, reported at least one negative act and/or bullying. Occasional negative acts, but no bullying, was reported by 34.9%, 5.6% reported regular negative acts but no bullying, 12.0% reported being bullied occasionally (regardless of negative acts experienced), and 4.1% reported being bullied regularly.

Six-month prevalence did not vary greatly across the three facilities, however, there were differences based on the program in which the respondent worked. It appears that the risk of experiencing negative acts and bullying from co-workers may be at least partially related to the level of patient-on-staff violence and abuse that occurs.

Of those who reported at least one negative act and/or bullying, a total of 21.5% reported that it seriously affected their work, 25.1% said that it seriously impacted their intent to remain in their job, and 25.5% said that it had a serious negative impact on their personal life (Table 1).

Table 1: Serious Impact (%), by Level of T3 Behavior Experienced

Serious ("a lot" + "very much") Impact				p<.001
	N	Work	Remain	Personal
Overall	483	21.5%	25.1%	25.5%
Occasional NAQ	294	8.5%	15.3%	11.9%
Regular NAQ	47	31.9%	25.5%	42.6%
Some bullying	105	36.1%	40.0%	40.0%
Regular bullying	37	70.2%	59.4%	70.2%
NAQ Only	341	11.7%	16.7%	16.1%
Any bullying	142	45.0%	43.1%	47.9%

Targets of the more serious and frequent Type III behaviors were significantly (p<.001) more likely to experience those three impacts. Of those who were regularly bullied, 70.2% reported that it had a serious, negative impact on their work, 59.4% said that it seriously impacted their intent to remain in their job, and 70.2% said that it had a serious negative impact on their personal life.

The impact on the target also varied based on the relationship of the perpetrator to the target (Table 2). The impact was greatest when a top manager was involved, slightly less when it was a direct supervisor, still less

when it was a peer, and least when it was a subordinate. This is further evidence of the role that power relations play in both the perpetration of Type III behaviors and the impact on recipients.

Table 2: Serious Impact (%), by Relationship of Perpetrator to Target

	N	Work	Remain	Personal	
Overall	483	21.5%	25.1%	25.5%	
NAQ Perpetrator	424				p<.001
Supervisor only	42	26.1%	47.6%	33.3%	
Top Manager only	36	27.7%	27.8%	41.6%	
Coworker only	143	12.6%	16.1%	16.8%	
Subordinate(s) only	44	4.5%	11.3%	11.4%	
>1 category, including supervisor or top manager	125	40.8%	40.8%	42.4%	
>1 category, but not including supervisor or top manager	34	17.6%	23.5%	14.7%	
Bullying Perpetrator	133				p<.01
Supervisor only	21	33.3%	47.6%	28.6%	
Top Manager only	17	52.9%	41.2%	58.8%	
Coworker only	36	44.4%	44.4%	52.8%	
Subordinate(s) only	10	0.0%	10.0%	10.0%	
>1 category, including supervisor or top manager	44	56.9%	57.1%	59.1%	
>1 category, but not including supervisor or top manager	5	60.0%	20.0%	20.0%	

There were slight, but not statistically significant, differences when the targets were stratified by gender, age, and ethnicity (Table 3).

Table 3: Serious Impact (%), by selected Demographics

	N	Work	Remain	Personal	
Gender	450				NS
male	138	21.7%	29.7%	21.7%	
female	312	20.6%	23.1%	26.3%	
Age	453				NS
<46	174	21.2%	28.8%	24.7%	
46-55	179	21.8%	22.9%	24.6%	
>46	100	18.0%	22.0%	25.0%	
Race	441				NS
non-white	47	29.8%	36.2%	29.8%	
white	394	20.3%	23.9%	24.6%	

The most common actions taken by the targets were *"told my supervisor"* (52.5%), followed by *"told the person to stop"* (38.5%), *"told the union"* (13.1%), *"sought counseling"* (7.7%), *"charged leave credits"* (7.5%), transferred job (4.2%), and *"completed an incident report"* (3.7%). Almost one-third (31.4%) stated that they *"pretend that it never happened"* (Table 4). Those who reported being bullied, particularly regularly, were more likely to take action.

Table 4: Likelihood of taking action, by type of T3 experienced

	Occasional NAQ	Regular NAQ	Some Bullying	Regular Bullying
	n=321	n=50	n=108	n=39
Told Person to Stop	32.9%	56.0%	46.3%	41.0%
Told Supervisor	45.5%	56.0%	68.5%	61.5%
Told Union	7.2%	12.0%	21.3%	41.0%
Sought Counseling	3.4%	8.0%	12.0%	30.8%
Charged Leave Credits	2.8%	10.0%	13.9%	25.6%
Went to EAP	0.9%	4.0%	9.3%	7.7%
Transferred Job	1.9%	8.0%	5.6%	15.4%
Filed an Incident Report	3.7%	4.0%	4.6%	0.0%
Pretended it Never Happened	26.1%	42.0%	37.0%	46.2%

Strengths and Limitations

One strength of this study was the use of standard definitions for co-worker conflict, including negative acts questions and workplace bullying, allowing comparison with surveys conducted on other working populations. Another strength was the use of PAR methods. This ensured that the survey would be relevant to the agencies and workforce, and was likely partially responsible for the high response rate, 68.0%. This makes it more likely that the responses are representative of the entire population of government-employed mental health workers who were surveyed. Each agency received a written report with their results, and with comparison data from all agencies combined. The promise of this report was used as a *"selling point"* to get agencies to agree to participate. Additionally, the agencies used the survey and the report to begin to seriously address the problem of co-worker conflict and workplace bullying.

One limitation, common to virtually all assessments of co-worker conflict, is the self-reporting, and therefore subjective nature, of much of the six-month prevalence reported here. Another limitation is that this was a cross-sectional survey.

Discussion and Conclusions

It is clear that co-worker conflict, including the negative acts and bullying reported here, has a significant impact. The impact appears to increase as the frequency and severity of the behaviors increase. While not directly assessed, it is likely that these behaviors impact the organization as a whole. This includes workers who are not directly being targeted, as well as the clients and patients being served.

This survey was conducted during a period when public funding for many government functions, including mental health services, had been flat or even cut. This, coupled with widespread political attacks on government work (and workers), likely added to the stress that the workers were experiencing. Where co-worker conflict and bullying are most severe, the organization's ability to deliver the services that are its mission is likely compromised. Therefore, for both humanitarian and operational reasons, it is incumbent that organizations address the problem of work environment and co-worker conflict directly.

This includes having clear norms of behavior, applying those norms to the entire organization, reducing stress on staff to the extent possible, having an effective system for individuals to report inappropriate behaviors, and for the organization to promptly and fairly investigate those reports and then take appropriate actions. Additionally, organizations should provide training to employees on the nature of co-worker conflict and bullying, as well as the efforts that they are making to prevent those behaviors and instruction on how targets should report problems.

Acknowledgements

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Learning objectives

1. Participants will gain knowledge on the impacts of different levels of bullying and coworker conflict.
2. Participants will gain knowledge on what actions are most commonly taken by target of bullying and coworker conflict.

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Case study of horizontal violence/hostility

Paper

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Focus: Research

Abstract

Nursing organizations are addressing the issue of *"Bullying"* and *"Horizontal Violence"* via American Nurses Association (2012) Bullying in the Workplace: Reversing a Culture and Dellasaga (2011) When Nurses Hurt Nurses: Recognizing and Overcoming the Cycle of Nurse Bullying by Sigma Theta Tau International (STTI). Briles (2008) stated that every workplace has the pit bulls; snakes who flick their abrasive tongues and voice; scorpions who sting with a slap of heavy backhand and skunks who seem innocent until you get in their space. *"Horizontal Violence/Hostility"* portrays aggressive behavior between individuals on the same power level (Bartholomew, 2006) whereas *"Bullying"* is the persistent, demeaning and downgrading of humans through vicious words and cruel acts that gradually undermine confidence and self-esteem (Adams, 1997; Dunn, 2003; Farrell, 2005). Dellasega (2010, 2009) discusses the impact of technology on Relational Aggression 24/7 via social media. The following is a case study.

It was November 2006; the nurse researcher at a children's hospital where she had been for five years received a call from a recruiter that she had been recommended for a Director of Nursing Research at another children's hospital. That December she was visiting her daughter in the Midwest so she called the co-Chief Operating Officer (COO) who she knew professionally to ask about the organization. The COO said *"Why don't you apply here since the Director of Research just resigned"*. Her daughter, a pilot, lived there with her son and aviator husband so she accepted the position and started July, 2007. The first three years she received great evaluations and funding to present at Hong Kong University, a Children's Hospital in Guangzhou, ROC, Fudan University in Shanghai, ROC and the STTI Research Conference in Singapore. She consulted with her Chinese, Japanese and Taiwanese colleagues to translate her boss's instrument, "Nurses Perception of their Environment" and presented the results at the 2009 STTI Nursing Research Congress in Vancouver, Canada. On February 9, 2010 her daughter called her from Puerto Rico that her 3 month granddaughter was in the Emergency Department (ER).
She met her grandson, son-in-law, and his fiancé/mother in the ER. The baby was transported to her hospital and diagnosed with *"Shaken Baby"*. The administrators offered their support. However the next day she and her daughter were not permitted to see their granddaughter and then things started to happen. That summer the former nurse researcher who had relocated to a university in another state returned to the hospital, becoming a Director over her. On March 7 this new Director gave her a verbal warning for telling a colleague that she should seek a BSN. On March 17 she had permission to attend an Enterprise meeting of the *"top"* Nursing Organizations in Washington, DC.
While there she received a call from her assistant as to her whereabouts. They had deleted her emails approving her to attend the meeting. The director moved her out of her office into a cubicle and moved into her office. Although the Co-COO gave her prior approval to attend the 2010 American Academy of Nursing (AAN) meeting and insisted that she nominate this Director for AAN Fellowship this Director denied her to attend and accused het of not having IRB approval for her Falls in Pediatric Patients study (she did). AAN requested that she present her study as a paper instead of a poster. She was terminated on November 1, 2010 because she defied the Director in submitting an abstract for the annual AAN conference. She pled her case to the State Appeals Court. In January, 2011, the Appeals Court ruled in her favor for wrongful termination. She returned to Florida and *"rebounded"* where she is treated with compassion, caring, integrity, dignity, honor and respect by her esteemed nursing colleagues.

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Learning Objectives

Following this presentation participants will be able to:
1. Define horizontal violence/hostility.
2. Identify an overt example of horizontal violence/hostility in the workplace.
3. Identify a covert example of horizontal violence/hostility in the workplace.
4. Discuss the impact the horizontal violence/hostility has on the individual and organization.
5. Relate why horizontal violence/hostility is so virulent.

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The lived experience of registered nurses witnessing horizontal violence in Ontario

Poster

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Focus: Research

Abstract

Horizontal violence (HV) is a type of workplace aggression that exists in nursing. There is significant research that identifies the consequences of HV to the victim but a paucity of research that explores the meaning of witnessing horizontal violence for nurses. The purpose of this study was to uncover the lived experience of registered nurses witnessing horizontal violence in Ontario. A hermeneutic phenomenological study was used to gain a deeper understanding, using in-depth, in person interviews. Three themes emerged: asking why; being in or being out; and between a rock and a hard place. These three themes lead to the discovery of one essential theme of being in-between. Being in-between is a difficult place to be for witnesses of horizontal violence. It is associated with high risk, cognitive dissonance and emotional turmoil.

These findings support a need for change in research, education, praxis and policy. Nurses are professionals that provide care to clients. It is time nurses extend this care to each other, setting a positive example of dignity and respect. With dignity and respect as a central component of nurse-to-nurse interaction, a supportive and safe environment will become entrenched in the culture. Horizontal violence has a long history in nursing and we can not expect that it will be resolved quickly. It will take a multifaceted approach to prevent future hostile nurse-to-nurse interactions that includes the witnesses as part of the solution. Prevention programs for bullying and harassment have been implemented in schools over the last decade. Many of these programs focus on interventions that address all students, faculty, and administrators. These programs focus on prevention, intervention and support (Janson et al., 2009). Nurses can learn from the ground work the education system has laid and adapt it to address the similar issues nurses face with horizontal violence.

Presenting in a workshop I would use a number of approaches to engage my audience. I would start the presentation with a story by quoting one of the participants. The example I will use will really tell the story and capture the essence of what means to experience witnessing horizontal violence. If accepted I plan to use power point presentation to provide a visual. I will invite the audience to tell their stories of witnessing HV. I will provide a handout for audience to follow along with the presentation. Audience members will be able to ask questions and contribute to the discussion on experiences and solutions to witnessing HV.

Learning objectives

1. Bullies rely on intimidation, fear, shame and silence. As witnesses of nurse-to-nurse hostility there is strength in numbers. If witnesses stand together and refuse to be silent, they can take away what bullies need most. When witnesses stand together, they protect the targets of HV and remove themselves from the pool of potential future victims.
2. A multifaceted approach is needed to resolve the long standing issue of horizontal violence in nursing and witnesses need to be included in the solutions.

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Integrating an action program in daily practice to stop and prevent bullying

Paper

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Focus: Research

Abstract

Background and context

Bullying is a public health problem that negatively affects health at workplaces. In the public sectors, including health care, it is more common with bullying problems compared to other sectors. Earlier research has primarily focused on incidence, prevalence, risk factors and relationships between bullying and ill-health. To a much lesser degree, research has focused on prevention. The aim of this study was to develop and implement an intervention to stop and prevent bullying at workplaces in collaboration with employees.

Methodology

This intervention study is integrated in a larger research project. Based on results from questionnaires targeting bullying, three workplaces in the healthcare sector were invited to participate. After approval from superiors, employees were invited to participate in focus-groups (FG), resulting in groups of 6-8 participants at one psychiatric ward in a county council, and two elderly care wards in respective municipalities. FG interviews were conducted twice; the first interview captured views on bullying, the second interview prepared for and developed the intervention. No superior participated in the first interview in order to have employees feel free expressing their views. Instead the department head was interviewed individually. The second included both employees and department heads. The FG interviews were analysed according to Grounded Theory.

Findings

The first interview revealed that the employees had insufficient knowledge about bullying and how to manage it. The second FG demonstrated that there were insufficient opportunities for reflections about bullying problems. Employees also expressed that they did not feel recognized and valued by superiors in higher levels of the organization.

Given this, the researchers have, as part of the intervention, held half-day lectures on the phenomena of bullying, conflict management, communication and shame. The intervention also contained discussions in small groups focused around game-cards that were specifically designed to initiate discussions about specific situations where bullying may occur and how one may prevent or manage this.

In the FGs, it was furthermore suggested to write a contract that ensured that everyone treats each other with tolerance and respect at the workplace. Both interviews revealed that managers play key roles in preventing workplace bullying. Appropriate leadership creates safety at the work-places, whereas inappropriate leadership creates fear.

Building on these findings from the FGs, next steps include plan of action, targeting e.g., compulsory, continuing discussions concerning bullying improved contact with the superior level and a workplace contract of mutual respect.

Suggestions for the action plan will be discussed in one additional FG, upon which the plan will be introduced to the directors of the workplaces for their support.

In summary the results of the findings are a developed intervention/action program consisting of lectures, game card-discussions and an action plan in collaboration with employees and managers.

Implications for practice, training and organization
Systematic longitudinal workplace interventions is one way of shouldering the responsibility of tackling bullying in workplaces, highlighting this often hidden problem.

Learning objectives

1. Bullying in the workplace is prevalent, and yet not acknowledged
2. Managers play key roles in preventing workplace bullying.
3. Leadership can contribute to safety as well as fear in the workplace.

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Comparing educational tools to address workplace harassment in Ontario hospitals: Workbooks to virtual world simulation

Paper

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Focus: Research

Study background

Nurses frequently experience workplace harassment. Workplace harassment is described as *"engaging in a course of vexatious comment or conduct that is known or ought reasonably to be known to be unwelcome"* (OHA, 2009). Workplace harassment, sometimes referred to as horizontal violence, includes such disrespectful behaviours as intimidation, bullying, criticism, exclusion, or belittling in public or private. Research findings demonstrate that workplace harassment often results in deceased productivity, morale and job satisfaction and increased sick time and job turnover (Baltimore, 2006; Speedy, 2006).

To foster a culture of respect and workplace safety, education programs have been used to increase awareness of risk factors, introduce prevention strategies, and practice effective means of dealing with workplace harassment (Beech & Leather, 2006). Although it is generally accepted that education is important, only a few researchers have evaluated the effectiveness of traditional educational interventions designed to increase staff knowledge, confidence and ability to address workplace harassment (Deans, 2004; Smith & Roehrs, 2009).

Furthermore, while traditional resources (workshops, eLearning modules, workbooks) provide useful information on workplace harassment, they fail to provide opportunities that realistically engage staff in practice using communication techniques, and de-escalation strategies. Simulation using mannequins has become popular over the last few years and a few studies have shown improved technical skill improvement and an increase in professional confidence (Bambini, 2009; Bradley, 2006; Laschinger, 2008; Maran, 2003). Role-play has been a key component in many of these educational interventions. The challenge with role-play, however, is in replicating scenarios that mimic real life situations and the role-play often becomes stiff, superficial, and unrealistic.

In the past, Second Life has been used primarily for recreation and social networking. Now it is beginning to gain recognition in the education and health care arenas (Hudson & Degast-Kennedy, 2009; Lance, 2007). Second Life is a 3D virtual world that provides opportunities for sensory immersive experiences, authentic contexts and activities for experiential learning, simulation role-play, and learning (Wiecha, 2010). A virtual world provides one of the most effective methods of imparting true-to-life learning experiences. According to Foster (2008), studies have shown that participants treat the environment in Second Life as if it were real, and feel the emotion associated with events more strongly than through in-person role play. Learning that takes place in a virtual environment has a more lasting impact, is more easily transferred to the workplace and provides participants with a comfort level that was previously felt only after experiencing the event in real life. Opportunities to practice in a safe and risk-free virtual environment facilitate knowledge transfer to challenging and stressful situations in the workplace.

Study purpose

This study is based upon a recent pilot study (Mallette et al., 2010). The work done during the pilot will be refined to evaluate the effectiveness of selected educational methodologies in supporting nurses to address workplace violence. Based on the findings of the pilot, use of virtual world simulation alone will not be included since it did not appear to be effective in the context of teaching/learning related to horizontal violence (Mallette et al., 2010). The scope of this study will be expanded to include both an urban teaching hospital and a multi-site community hospital within two geographical settings in Ontario. In addition to building on the findings of the pilot study, the proposed study will also include information on workplace violence as outlined in Ontario's Bill 168 Occupational Health and Safety Amendment Act. The Registered Nurses Association of Ontario's (RNAO) Best Practice Guidelines on Healthy Work Environments (2009) highlight the importance of fostering a culture of respect through the elimination of workplace violence. Bill 168 specifies that an employer develop and provide information and instruction on the contents of its policy and program addressing workplace violence and harassment.

Significance of the study

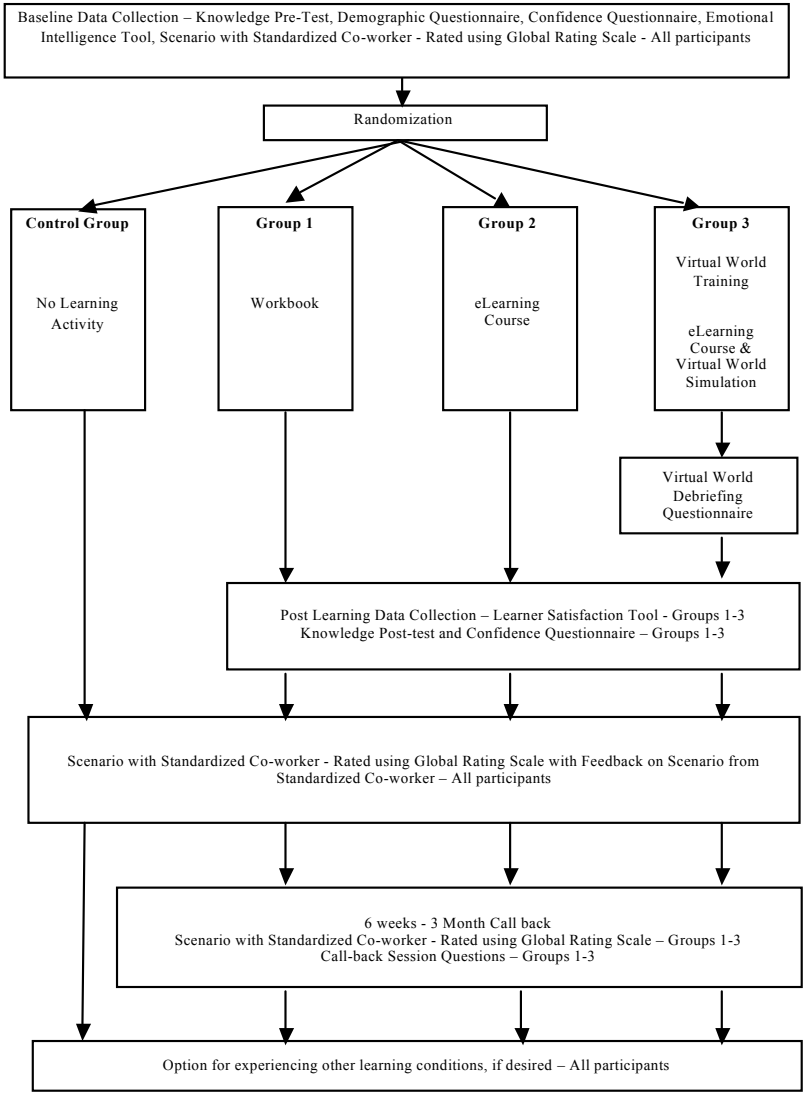
The project will inform organizations and the province about emerging best practices in education regarding workplace harassment and offer a number of educational tools from which to choose. Results from testing the different methodologies in a variety of healthcare settings will better inform organizations as to which one(s)

would be most suitable for their own setting. Equally important is the study's contribution to the body of knowledge related to technology supported educational methodologies. Engagement in scenarios involving workplace harassment in a realistic Virtual Nursing Unit should enable learners to repeatedly practice strategies for addressing workplace harassment, reflect upon their actions, receive feedback and try new strategies in a safe and risk-free environment that is much more realistic and engaging than the traditional methods. This study will ultimately increase nurses' awareness of the organization's policy and program related to workplace harassment as required by Bill 168, improve nurses' ability to deal with workplace harassment, and encourage nurses to report incidents of workplace harassment.

Research hypotheses

Satisfaction, knowledge acquisition, confidence, and the ability to address a workplace harassment incident will be greater for participants who participate in Virtual World simulation compared to those who participate in non-experiential instructional strategies (workbook alone or eLearning alone). Participants with higher baseline EI scores will exhibit a greater ability to address a workplace harassment incident than participants with lower EI scores.

Figure 1: Data collection process



Research questions

- What is the effect of learning about workplace harassment using simulation in a virtual world environment compared to traditional educational programs of a workbook or eLearning?
- How do participants perceive the educational value of the various educational methods used in the study?
- Does perceived professional confidence change after an educational intervention?
- What is the relationship, if any, between age, emotional intelligence, or type of work setting and participants' ability to recognize and address workplace harassment?
- Do knowledge, confidence, and the ability to address a workplace harassment incident persist over time?

Research design and data collection process

A quasi-experimental effectiveness study was used to evaluate 3 different learning strategies. Data were collected as illustrated in Figure 1.

Descriptive statistical tests have been performed to characterize demographics. Independent t-tests are being performed to compare the pre and post knowledge test results and confidence ratings for each participant. One-way ANOVAs will be used to compare group differences. For variables that were tested identically in pilot study, further analysis will be performed on both data sets to increase statistical power n=330.

Results

The results will be presented at the conference.
Statistical analysis will include summative data analysis from both the pilot study and the current study n=330.

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Learning objectives

1. Educational strategies are needed to help nurses effectively deal with workplace harassment.
2. Virtual world technology provides a unique forum for educational strategies dealing with workplace harassment with very positive outcomes.

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Reporting a bullying: Responsibility of a frontline manager

Paper

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Focus: Practice
Keywords: Bullying, mobbing, malign, nonmalign, mediation, arbitration

Abstract

Canadian frontline managers are observing an increase in the reporting of workplace bullying as more nurses become aware of their employers' legal obligations to provide employees with a respectful workplace, per the Canada Human Rights Code, Canada Labor Code, and Canada Occupational Health and Safety Regulations. One problem with this reporting is that the victim's reports of bullying may become overshadowed by the bully's reports of victim incompetence, resulting in the victim experiencing further victimization. Bullies may report the victim (target) as inept, deficient in knowledge, or lacking ability. Fear of re-victimization plays a significant role in the victim's failure to report workplace bullying. It is important that managers focus on the bullying and not the perceived character flaws described by the bully. The author begins by describing workplace bullying and reviewing the workplace bullying literature. She then presents and discusses a composite case study. To assist managers in discouraging bullying she shares supports for addressing bullying, specifically workplace policies, collective agreements, human resources departments, mediation, alternative dispute resolution, and arbitration, and concludes by reminding frontline managers of their important role in identifying bullying and understanding the victim's fears of further victimization.

Responsibility of a Frontline Manager Regarding Staff Bullying

Bullying behaviors among nurses are finally gaining the notice of health care leaders who increasingly struggle to control high operating expenses, such as the rising costs of absenteeism, orienting new staff, employee benefits, mediation, and arbitration resulting from bullying behaviors. Leymann, already in 1990 suggested that when managers step in to address the bullying, they may have the tendency "to take over the prejudices of the victim's workmates…and those around regularly assume that the cause of the problem lies in the deviant personality of the victim' (p. 121-122). Others have described how the victims (targets) of bullying frequently become distressed when defending allegations made about them by the bully who publically describes them as inept, unsuitable, deficient in knowledge, and/or lacking ability (Hutchinson, et.al. 2010; Rocker, 2008; Warren, 2011).

In these cases the initial issue of bullying may become overshadowed by the negative descriptions the bully uses to talk about the victim. The bully may describe the victim as incompetent, lazy, or not a fit for the workplace. Skilled bullies usually have no difficulty seeking out support from others when describing the incompetence of their victim (Hutchinson, 2009; Rocker, 2008; Vickers, 2011).

The composite case study described below (developed based on my various leadership experiences in addressing bullying) illustrates the negative outcome that can occur when a frontline manager focuses on the character flaws of the victim (target) rather than on listening to the victim's present fears and concerns. In this article, which represents a Canadian perspective, I will begin by describing workplace bullying and reviewing the workplace bullying literature. Next I will present and discuss a composite case study of bullying. To assist managers I will share helpful supports for addressing bullying, specifically workplace policies, collective agreements, human resources departments, mediation, and arbitration. What is distinctive to Canada is the official Acts that legally require the employer to protect the mental and physical health of employees from bullying and harassment (Occupational Health and Safety Council of Ontario, 2010). The frontline managers' actions towards bullying behaviors must be consistent with the legislative amendments made by the Canadian government to provincial occupational health and safety acts.

Defining Characteristics of Bullying Behaviors

Bullying behaviors are either malign behaviors or nonmalign behaviors (Durniat, 2010; Rigby, 1996). Malign bullying implies that the bully consciously seeks to harm another while at the same time as repeating and enjoying the behavior (Durniat, 2010). A malign bully has a desire to hurt and regularly directs the behavior from a more powerful group to a less powerful individual (Farrington, 1993). Malign bullying often includes slander in which an untruth that will harm the reputation of the individual being bullied is told.

Nonmalign bullying (mindless and educational bullying) is unintentional yet also hurtful to another. In mindless bullying the person is unaware that his or her behavior is harmful, and is not hateful or cruel toward others. It involves criticizing and engaging in an insensitive exposure of a persons' limitations leading them to believe that they are inferior. For example, educational bullying is a practice whereby someone possessing knowledge (nurse

educator) may deliberately withhold information or make the individual fell inadequate, clumsy, or foolish in front of others when he or she cannot answer a question.

As part of this discussion it becomes important for frontline managers to separate bullying from incivility. Bullying should not be confused with workplace incivility. Incivility manifests in disrespect, rudeness, and general disdain for others; for example, rolling of the eyes (Luparell, 2011). Although one may behave with incivility towards another person it does not mean that they are displaying bullying behaviors. Incivility implies lack of politeness, offensive comments, and rudeness. Increased workload and organizational change have the potential to increase employees' anger and stress causing them to express uncivil behaviors towards others, sometimes in the form of withholding information and knowledge (Shim, 2010).

In contrast, bullying suggests inappropriate, unwanted, vexatious, and hostile behaviors toward others (Luparell, 2011). For example, bullying behaviors include interactions in the workplace such as using hand gestures to ward off conversation and reviewing documentation of others for the purpose of finding and reporting errors (Anastasius, 2010).

Review of the Literature

In the 1980s the Swedish psychologist, Heinz Leymann, pioneered the study of workplace bullying. The work of Leymann became a benchmark worldwide for treating the oppressed and traumatized worker (Leymann, 1990, 1996). Sweden became the first country in the world to establish an Ordinance against Victimization at Work. Victimization has been described as *"recurrent reprehensible or distinctly negative actions which are directed against individual employees in an offensive manner and can result in those employees being placed outside the workplace community"* (Namie & Namie, 2009, p. 260).

Georgio (2009) has suggested using an interactionist perspective, looking at interactions between the person and the environment, to explain bullying. Georgio observed that bullying behaviors generally occur over a six-month period in which people are exposed to negative behaviors affecting their work tasks. Frequency and duration of bullying are apt to make the target person powerlessness because bullying drains the target of his or her coping resources (Leymann, 1996). The imbalance of power makes it impossible for the target to retaliate or effectively protect him or herself (Einarsen, Hoel, & Notelaers, 2009).

Leymann (1996) proposed that organizational factors and leadership problems caused bullying. In contrast, Hoel and Einarsen (2010) suggested that these leadership problems do not harass. Rather the true cause of bullying may lie in the social group in that bullying is more likely to happen in a social group because the victim experiences and suffers from social exclusion (King-Jones, 2011; Schuster, 1996).
A survey by Katrinli, Atabay, Gunay, and Cangarli (2010) found that horizontal bullying among nurses may be deliberate, resulting from organizational structures and politics. Deliberate horizontal bullying might be a rational strategy used by perpetrators completing for promotion, preferred assignments, performance appraisals, allocation of resources, and recruitment. For example, if the organization has an individual, performance-based, reward system, employees may complete for a top position by bullying each other. Characteristics of these nurses, who bully may include self-interest, need for power, personal problems, and/or psychological difficulties. Rocker (2008) and Anastasius (2010) have suggested that the nurse manager should provide structural support for nurses on the nursing unit by changing the unit rules, unit behaviors, and establishing a blame-free culture. For example, incident reporting should focus on system factors that cause errors and not be used as a bullying tool for 'writing–up' nurses for social control or dishonoring them.

In 2000, the Canadian government amended the Canada Labor Code Regulations necessitating that the employer take set steps to protect employees against, and to stop violence in the workplace (Human Resources and Skills Development Canada, 2011). As of 2011 bullying is illegal in two provinces (Saskatchewan and Quebec) and the remaining provinces address workplace bullying through provincial Occupational Health and Safety Acts (Human Resources and Skills Development Canada, 2011; Province of Saskatchewan, 2007). Yet bullying remains rampant in the workplace and victims often find themselves in vulnerable situations in which a power imbalance exists between them and the frontline manager. The following composite case study exemplifies this imbalance and demonstrates the undesired consequences of bullying.

Composite Case Study

Over my many years as a nurse manager, educator, and staff nurse I have observed various types of bullying behaviors among nurses. Although each case of bullying is unique to the target, the actions of the bullying often share a common theme, namely triangulation. Canadian nurse Betty (not her real name) and her friend present a typical example of triangulation, in which a bully gives minimal information to the manager suggesting the manager might want to investigate the nurse's (target's) debatable practices. Triangulation is used to cause unit unrest, freezing someone out of the unit, preventing another's advancement, and/or challenging the frontline manager's leadership abilities (Katrinli, et al., 2010; Szutenbach, 2008). A typical example of triangulation, one that I have witnessed, occurred when a nurse bully suggested to the frontline manager that she was concerned that an advanced practitioner, new staff member, or someone with higher education may not grasp a concept or 'get it.' The bully never defined 'not getting it' but merely planted the seed in the mind of the manager that something was wrong and should be investigated—an investigation that may take on the prejudices of the victim's co-workers(s).

To illustrate, Betty, a nurse with a postgraduate degree, working day-evening casual shifts, shared with the charge nurse that she has been bullied by a physician. She explained that the physician had thrown equipment across the room, grabbed equipment out of her hands, and told her that *"in no circumstances would he look after her if she were injured."* Each of these behaviors occurred front of patients. Betty felt embarrassed, and was in disbelief, by the actions of the physician. She told the charge nurse about the incident requesting that the charge nurse keep the conversation confidential. Unknown to Betty the charge nurse reported the matter to the nurse manager.

Without explanation, Betty was summoned (on her day off) to report to the manager's office. After the nurse manager discussed the bullying incident, he assured her that the nursing unit had never experienced any types of bullying behaviors in the past between a physician and nurse. In fact, his position was that of zero tolerance for bullying behaviors. He encouraged her to report the incident.
Not wanting to draw attention to the incident for fear of reprisal, Betty declined his invitation to report the incident. The nurse manager did not take any further action with Betty, and the incident was never again discussed with her. The following day, however, a coworker informed Betty that after her meeting with the manager he immediately made, rounds on the nursing unit asking if anyone had any concerns with this physician. One staff member did report seeing the physician bullying two other nurses during a procedure. Again, the manager did not follow up, for example, by reviewing respectful workplace policy.

Once the incident was known throughout the nursing unit (via the grapevine) Betty believed that she was being re-victimized by the charge nurse. The charge nurse began scrutinizing her documentation, looking for gaps in reporting, and revealing any findings to the frontline manager. Betty also heard the charge nurse, and the staff nurse who had reported the incident with the physician, gossiping at the desk with reference to reporting her practice. As she approached the desk they become silent and turned away.
The next day the nurse manager summoned Betty to his office (during her time off), refusing to provide any rational for this summons. Betty refused to attend the requested meeting. The nurse manager informed her that the charge nurse believed that her charting lacked evidence of critical thinking (a subject that she has studied for years). Betty became very disheartened by the lack of managerial support in her practice.

One day Betty experienced fear and vulnerability when she was asked to meet with the nurse manager without explanation. She remembered her friend, a registered nurse (RN) with six years of experiences telling her about her personal experience with bullying while working with a registered practical nurse (RPN). According to her friend the RPN 'took exception' when she offered her advice on solving practice issues. The relationship between the two nurses became so strained that the RPN stopped communicating and Betty's friend found herself in tears. In hopes of re-establishing communication with the RPN, Betty's friend sought out guidance from her nurse manager. She shared with the nurse manager the RPN's behaviors: gossiping, stopping conversation with others when she approached, and posting notes about her on Facebook. After sharing her feeling with the nurse manager for the second time Betty's friend thanked her manager for listening and asked her to keep the conversation confidential.

Instead of keeping the conversation confidential, the nurse manager confronted the RPN and arranged for mediation between the two parties. Perplexed and 'feeling defeated' by the nurse manager not respecting her request for confidentiality, Betty's friend had sought out support from a union steward. Much to her friend's surprise the union steward was already aware of the situation.

A mediation time was set and the following people attended: nurse manager, Betty's friend, union steward, RPN, RPN's support person, and the mediator. The mediator interviewed both Betty's friend and the RPN before the meeting, starting with the RPN. During the meeting Betty's friend had felt that the mediator was not listening to her story. The nurse manager contributed nothing to the conversation. The union steward recommended that Betty's friend not sign the mediation agreement in its present form because it lacked language that was consistent with mediation (a process for resolving disputes, not for disciplining) (Ontario Human Rights Commission, 2011). After rewriting the agreement Betty's friend agreed she would work to improve communication, not discuss the incident with others, and attend a follow-up discussion.
After returning to work, however, Betty's friend continued to hear others gossiping about her and believed that she was experiencing acts of re-victimization. Sadden by the situation she removed herself from Facebook. Fearful of working in a hostile environment, she quit her job and went to work in another hospital.

Betty, herself, was afraid of being re-victimized at the hands of other nurses hearing her story. She did not want to spend her time off at management meetings re-living, ruminating, and defending accusations made about her by others. She was concerned that these accusations might cause her to develop a stress disorder. Betty left her employment without knowing if the true bully would be identified; namely the staff nurse who reported the physician, gossiped, and coordinated the actions of others.

Discussion of Composite Case Study

This composite case study illustrates that both nurses left their positions because of the fear of re-victimization. It shows how a hostile work environment in which a bully targeting Betty was capable of orchestrating the nursing staff so as to control, manipulate, and direct the decisions and behaviors of a frontline manager. Lacking the support of their nurse managers and fearing future victimization, both nurses left their positions. Betty thought she could not report bullying behaviors if the nurse manager did not even recognize that a bullying problem even existed on the nursing unit.

Betty and her friend both believed that their nurse managers had betrayed their request for confidentiality and failed to provide a respectful work environment even thought, according to the Ontario Human Rights Commission (2011), every employer has an *"obligation to provide employees"* (p. 1) with a healthy working environment that addresses and prevents harassment. Because the boundaries between incivility and workplace bullying are not clearly evident, it may be difficult to distinguish between them and assess the cause and the effect of a given behavior. Additionally many frontline managers who are responsible for resolving conflict in the workplace lack the preparation and education needed to address these issues.

Supports for Addressing Bullying

When nurse managers are confronted with reports of bullying, it is important that they listen to the staff member's story to assess the situation thoroughly and seek to determine whether a problem of bulling exists (Creswell, 2005). After establishing the validity of reported bullying, including either malign or nonmalign bullying, frontline managers should meet with the concerned employee. Employees need to be informed of their legal right to have union representation (steward) or other representation at the meeting (British Columbia Nurses Union [BCNU], 2011; Saskatchewan Union of Nurses [SUN], 2011; United Nurses of Alberta [UNA], 2011).

As of 2012, the Canadian Federation of Nurses Unions (CFNU) represented 156,000 nurses and student nurses (CFNU, 2012). As a national voice the CFNU makes the Prime Minister, Minister of Health, and members of parliament aware of nursing's perspectives and positions related to policy making. At provincial levels each province has its own nursing union. For example, the Manitoba Nurses Union (MNU) is an organization dedicated to ensuring members' voices and grievances are heard, and that agreements are negotiated for salaries, benefits, and working conditions (MNU, 2012). At the national level in the United States (US) the American Nurses Association makes members of the U.S. Congress and other relevant bodies aware of nursing's perspectives and positions related to policy making. Individual states have their individual nursing associations that have varying levels of union involvement.

According to the Canadian Center for Occupational Health and Safety (CCOHS) a non-union employee may seek council from an Employee Assistance Program (EAP), a service often purchased by the employer to manage difficult situations (CCOHS, 2009). A victim of bullying may also obtain support and advice from a physician, psychologist, or lawyer, and may gain access to sick leave, workers' compensation, or employment insurance. The frontline managers may seek information and problem-solving strategies from their immediate supervisor(s) the resources described below, namely workplace policy, collective agreements, and human resources management departments, as well as mediation, alternative dispute resolution, and arbitration tools.

Workplace Policy

Canadian workplace safety regulations are determined by the federal government and administered by provincial Occupational Health and Safety Acts (Canadian Initiative on Workplace Violence, 2007). In 2011, the province of Manitoba amended its safety act and passed Bill 219—The Workplace Safety and Health Amendment Act (Harassment and Violence in the Workplace) (Legislative Assembly of Manitoba, 2011). Harassment was defined as "behavior of a person, either by repeated conduct, comments, displays, actions or gestures, or by a single serious comment, display, action, gesture or occurrence of conduct, that is

(i) unwelcome, vexatious, hostile, inappropriate or unwanted
(ii) based on race, creed, religion, skin color, sexual orientation, marital status, family status, disability, physical size or weight, age, nationality, ancestry or place of origin, or
(iii) an improper use of the power or authority inherent in the person's position" (p. 1).

The Bill requires employers to develop policies that investigate allegations of workplace harassment and violence, and start violence prevention programs; it gives the worker the right to refuse to work in some situations. In 2010 Ontario introduced Bill 168 to address workplace harassment (Occupational Health & Safety Council of Ontario [OHSCO], 2010), considering workplace harassment to be *"engaging in a course of vexatious comment or conduct against a worker in a workplace that is known or ought reasonably to be known to be unwelcome"* (p. 26). In addition, Bill 168 requires the employer to develop written policies, expand and maintain programs that implement policies, and review these policies at least once a year.

According to the OHSCO (2010) developers of workplace harassment policy and programs must know their legal rights in relations to the Occupational Health and Safety Act, Ontario Human Rights Code, and workplace collective agreements. The OHSCO has noted that policy development begins with gathering information from workers, current policies, and programs, and that the policy *"should include a high-level statement on the commitment of senior management to protecting workers, investigating incidents, and dealing with incidents"* (p. 1). Measures and procedures for reporting and investigating the incident should:

- Include how to report the incident
- Include how the employer will investigate and deal with the incidents
- Include how to report harassment originating with the manager
- Establish trainers (workers and supervisors), and
- Consider supplementary training—workplace harassment awareness, prevention, or provincial (Ontario) human rights issues.

Collective Agreements

Either the target or the bully may ask the union for assistance in resolving conflicts such as bullying (UNA, 2011; SUN; 2011). Therefore, it becomes imperative that frontline managers become very familiar with their workplace collective agreements. Collective agreements are established at provincial level and address the terms and conditions of a nurse's employment (UNA, 2011). According to the United Nurses of Alberta (UNA) a dispute between nurses is an unlikely topic for alleging and violating the collective agreement; instead disputes usually affect employer and employee relationships (UNA, 2011). When considering a complaint of bullying against another employee, the union's Labor Relations Officer and local grievance committee give advice to the employee regarding the grievance process. The grievance process includes:

- An attempt to dialogue with the immediate manager to settle the dispute
- (If unresolved) a submission of the grievance to the Director of the Department with the expectation that the director will response within a stated time frame (usually 10 days)
- (If unresolved) a submission of the grievance to the administrator to resolve within a declared duration of time
- (If unresolved) a submission of the grievance to a mediator (however, the mediator's decisions are not necessary binding), and
- (If the decision of mediator is unacceptable) a submission of the grievance to an arbitrator who awards a final and binding decision for both parties to follow.

Human Resources Management

Vancouver Island Health Authority's (VIHA's) Respectful Workplace People and Organizational Development strives to provide a workplace in which employees are treated with respect and dignity, without discrimination or harassment and are supported in managing workplace differences (VIHA, 2009). The frontline manager may seek support from a Respectful Workplace Specialist to achieve resolution of the complaint. The Respectful Workplace Specialist is someone who offers human rights education, assistance, and advice. For example, the Respectful Workplace Specialist may provide confidential advice and coaching to frontline managers regarding harassment issues, ease group interventions, complete an initial assessment, and/or act as a case manager for formal complaints. The Executive Director of the Respectful Workplace People and Organizational Development decides time limits for filing a formal complaint and approves an investigator or mediator for formal complaints.

In union environments disputes may also be solved using informal or formal resolution processes (VIHA, 2009). The informal resolution process involves directly speaking with the individual, whereas the formal resolution process involves a formal complaint, investigation process, remedies, closure, and follow up. In those parts of Canada where unions do not exist, employment standard legislation and human rights legislation is followed (Government of Canada, 2011). In these non-union environments conflict resolution may be overseen by a lawyer, psychologist, self-help group, conciliator, mediator, or arbitrator.

Mediation

Mediation is a process for resolving disputes between two or more persons in private and without going to court (Government of British Columbia, 2011). The trained mediator has no discussion-making power; instead, the mediator helps people settle a conflict by separating the person from the problem. Mediation can occur if both parties are willing to meet together and neither one can ignore the problem. Mediation also addresses impasses in which complex cases require creative solutions; both parties want to maintain a future relationship; and a need exists to resolve behavior issues. Mediation does not work in situations in which there is an unwillingness on the part of one or both of the parties to compromise, or when there is fear of violence, or to challenge or change a law.

Alternative Dispute Resolution

Alternative Dispute Resolution (ADR) is a voluntary process that helps two or more persons in reaching a resolution (Government of Canada, 2011). The process is confidential and involves a neutral third party. ADR can offer the advantage of reducing drawn out and costly litigation. ADR is also less confrontational than mediation and arbitration, and can help individuals maintain a working relationship. The disadvantage of ADR is that the neutral third party cannot issue orders requiring parties to change their behaviors.

Arbitration

Arbitration is the oldest form of dispute resolution. According to Saskatchewan Union of Nurses (2011) either the union or employer may notify (in writing) the other party of a desire to revolve difference using arbitration. Time limits are placed on the procedural steps of the arbitration so as to maintain procedural orderliness. If the employer and union do not appoint a chairperson to the Arbitration Board, the Minister of Labor makes the appointment. The Arbitration Board hears the differences and renders a decision; however, the board cannot substitute, alter, or amend the provisions in the collective agreement. In a non-union environment an arbitrator may be hired by contacting the local courthouse; however, both parties must agree to the arbitrator.

Conclusion

Simons and Mawn (2010) have described the considerable economic consequences for organizations when nurses leave their jobs because of workplace harassment, incivility, and/or bullying. These economic costs include the considerable costs of recruiting, hiring, and orienting new employees. The composite case study presented above illustrates that nurses do recognize bullying behaviors, yet often believe they are powerless to change these behaviors. It is important that frontline managers take nurses' complaints seriously, act on them promptly, and use appropriate resources to resolve the conflict situation according to organizational anti-bullying, respect-promoting workplace and harassment policies. Frontline managers also need to recognize that nurses may be unprepared to participate in any form(s) of resolution because of perceived power imbalances between the nurse and the manager and/or the fear of re-victimization. It is essential for frontline managers to understand the fears of further victimization that are often held by victims of bullying, and work to shift the focus from the victim to the bully, as they work to achieve conflict resolution and maintain a respectful work environment.

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Learning objectives

1. Using a best practice approach to resolve staff conflict front-line managers should focus on the issue at hand; bullying and not the perceived personality or character flaws of the target.

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Responses of staff nurses experiencing horizontal violence

Poster

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Focus: Research

Abstract

Background and context

Horizontal violence consists of any action taken by one staff nurse against another staff nurse that will compromise her well-being or impede her ability to perform her professional duties. It is an overwhelming problem among nurses worldwide. It is a problem in Quebec as well. Horizontal violence may take on many forms yet, it remains under-recognized.

The consequences of horizontal violence on the nurses well-being have been previously reported. It has been linked to stress, depression, substance abuse and suicide. It also may affect nurses professional performance as a result of lowered self-confidence or a breakdown in communication between colleagues. On an institutional level, results of horizontal violence may include a high turnover of nurses, frequent sick leave and early retirement.

Because horizontal violence may be triggered or exacerbated by organizational changes, as are occurring throughout the healthcare system at the present time, it has become a priority to have a better understanding of the problem. We know a lot about the forms and consequences of horizontal violence, but no study has been conducted on the subject of the responses of the staff nurses who are victims of horizontal violence. This information could be useful in an effort to minimize the negative impact of horizontal violence on nurses who are victims, on the quality of patient care as well as on healthcare institutions.

Methodology

In the context of this exploratory study, we will conduct six individual semi-structured interviews with staff nurses who are or were victims of horizontal violence. The ninety minute interviews will aim to describe the nurses personal experience of horizontal violence and will focus on the responses of the nurse to the act of violence as well as the eventual outcome.
Participants will be recruited on a voluntary basis in a Montreal tertiary care university hospital. All necessary attention will be given to insure confidentiality and anonymity as well as the well-being of the participants. We will seek ethics board approval for this study.

Findings and implications

The question of how staff nurses respond to horizontal violence having never been addressed, our study is expected to have practical implications. Firstly, we will learn how nurses respond to horizontal violence. Secondly, we will learn how individual responses affect the outcome of situations of horizontal violence.

The findings will enable administrators to view horizontal violence in a new way and allow early recognition of acts of violence and identification of constructive and effective responses. This information will aid Employee Assistance Programs in offering training aimed at staff nurses and managers, and in developing resources for improving overall job satisfaction and nurse retention.

Learning objectives

After this presentation attendees will:
1) Have a better understanding of the impacts of horizontal violence on nurses, the quality of patient care and the health institution.
2) Recognize the importance of conducting further research in order to minimize the impacts of horizontal violence.

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Workplace bullying in the health and social care systems in Sweden: Perspectives on identifying and defining victims

Paper

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Focus: Research

Abstract

Background and context

Given its negative consequences on health and wellbeing, workplace bullying is a public health problem. Bullying seems to more commonly thrive in the public sector, including health care, as compared to in the private sectors. The aim of this project was to describe workplace bullying within the specific context of the health and social care systems in Sweden from both a quantitative and qualitative perspective. The resulting data was intended to serve as a foundation for a workplace intervention against bullying. The current paper presents quantitative descriptive results and results from an integrated approach to identify victims of workplace bulling.

Methodology

Baseline data was collected at nursing hospitals wards and eldercare municipal wards in two regions of Sweden. The mailed questionnaire (n= 1550, response-rate 55%) included several validated instruments targeting bullying, health, workplace environment and background data. Respondents were also asked whether they had been bullied or witnessed bullying in the past 6 months, and/or previously in life. Consequently, bullying was measured with an operationalized (The Negative Acts Questionnaire, NAQ-R) and a self-labelling (whether the person had been bullied or had witnessed bullying the last 6 months) approach. In addition, both approaches were incorporated into a single latent class cluster model, controlling for age, gender, education, ethnicity, profession, and factors related to employment and family/ household.

Findings

With the operational approach, 18,5% of respondents were bullied according to Leyman's criterion of exposure to at least one negative act/week during six months, and, 6,8% according to Mikkelsen and Einarsens criterion of 2 negative acts/week during six months. With the self-labeling approach, 4 % of respondents were bullied. The results of the integrated approach, however, showed that the latent class cluster solution with the best fit revealed five latent clusters or groups that are exposed differently to workplace bullying behaviors: (1) no exposure to negative behaviors (52.0%), (2) only rarely bullied (25.4%), (3) endorsement of mostly work related NAQ items (11.9%), (4) likely to respond occasionally to negative behaviors (9.0%), (5) most likely to respond weekly or more often exposure to negative behaviors, i.e., severe targets or victims of workplace bullying (1.7%). The latter group was by far most likely to describe themselves as victimized. Preliminary analyses suggest that moderate and severe targets of bullying have significantly lower health status. Furthermore, respondents who had been bullied earlier in life were more likely to currently experience bullying. Almost one fourth of respondents had witnessed bullying, and, over a third had experienced bullying earlier in life.

Implications

Our results confirm bullying as a public health issue needing concern, and it brings special attention to bullying the health care sector. Although there are more types of targets than victims alone, only victims have a substantial probability of labelling themselves as victims. Given the hesitancy to see and identify oneself as a target, it is important to increase knowledge and awareness of workplace bullying in health care contexts. Repeated exposure to bullying is, in itself, harmful, and, as was revealed by the negative health scores of the occasionally bullied cluster, agreeing with the definition is not a necessary condition for suffering health consequences.

Learning objectives

1. Learn about characteristics of workplace bullying in the Swedish health and social care systems, as highlighted by this study.
2. Learn about/discuss strategies to define and identify victims of workplace bullying; drawing on data from this study, including an integrated approach (latent cluster analysis).

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Using a coaching method to manage bullying, mobbing, and intimidation in the workplace

Paper

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Focus: Education and Training

Abstract

Bullying, intimidation, and mobbing occur in healthcare and affect the moral integrity of health care providers as well as patient care. Patient safety is affected, and the team in healthcare teams is gone. There are many types of violence that are affecting workers within the healthcare environment. This violence can be intended, indirect, or unintentional. Healthcare needs to embrace new methods to address such interpersonal conflict. Coaching is one newly emerging and promising solution.

There is a growing body of research telling us that ongoing health care restructuring, a lack of human and structural resources, altered work environments, increased patient acuity with offloading of care to families, and the uncritical adoption of a rigid corporate ethos in the Canadian healthcare system have led to significant pressures on nurses and other healthcare providers in most arenas of practice (Rodney et al., 2013). Participatory action research has shown the importance of respect and transparency in communication between all health care provider groups (Rodney et al., 2013).

Based on this research, the presenter has explored coaching as a positive interpersonal tool of bonding and education experience which provides opportunities for healthcare professionals to address interpersonal conflict and other issues. Coaching is the leadership process for the new millennium. It is a potent communication that helps people connect to the performance of the team and to the things that are important in their lives.

In order for coaching to thrive, health care needs to adopt a coaching culture through all levels of the organization. This coaching culture would enable the person being bullied and the bullying person to access coaches. By engaging in an ongoing coaching program, workers who are bullied and the workers who bully gain knowledge and confidence to manage situations where bullying and intimidation occur. Coaching helps to explore the psychosocial aspects of caring, and helps to address the emotional stress of the workplace in a respectful and compassionate manner that makes the lives of health care providers richer and more productive.

Reference

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Learning objectives

1. Introduce the concept of coaching.
2. Corporate wide adoption.

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Lateral violence within the nursing profession

Poster

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Focus: Guidance

Abstract

Background

There is an epidemic of lateral hostility and bullying in healthcare and especially within nursing that has caught the attention of the Joint Commission (JC), and American Nurses Association (ANA). The two organizations have made bold attempts to raise the awareness of healthcare staff and have developed new standards to help stop these patterns. With the implementation of these new standards many institutions have established zero tolerance policies. Review of the international literature reflects the ineffectiveness of the enactment of stand-alone zero tolerance policies.

Methodology

A qualitative study done in the United States affirmed literature findings that bullying and lateral violence are prevalent within nursing.

Findings

Bullying and lateral hostility have evolved over nursing's long history and have become engrained within the profession. In one case the evidence from this study supported the work of Hutchison, Vickers, Jackson and Wilkes (2005) showing organizational bullying of individuals. It is critical for all nurses to understand the root causes of these behaviors and their evolution in order to begin to develop new and healthy work relationships with one another.

Through a review of the literature four key factors emerged as causes for nursings patterns of lateral hostility and violence. They are 1) the early paternalistic work environment which was disempowering, 2) the learned behaviors of lateral violence proliferated within nursing educational programs and within practice, 3) the acceptance of these bullying behaviors as normal for the profession, and 4) subtle indoctrination to consistently avoid circumstances where assertiveness was required.

Assuming that these factors are central drivers of the lateral hostility between nurses several important steps are needed. The first step is a deeper understanding of the interpersonal relationships with professional colleagues, and the second includes developing greater confidence and assertiveness in the workplace.

For deeper understanding of specific events of violence, sound reflection is needed. The six steps of the Gibbs Reflective Cycle serve as an excellent guide for this activity. The six steps include 1) a description of the event, 2) feelings/emotional response, 3) subjective judgments (good and bad) associated with the event, 4) an attempt to make sense of the event, 5) conclusions about the circumstances and individual reaction, and 6) possible alternative future actions. This model will be applied to an example event to show how new insight may be gained through reflection. Literature on reflection encourages individuals to use the model in personal journaling or in a conversation with a trusted leader or colleague. Additional reflective and debriefing models offer alternative reflective questions that may better suit different individuals and help them grow and develop greater depth of understanding of their own painful experiences.

Some examples of ways nurses can become more assertive with aggressive and abusive peers will also be provided in the presentation. This portion of the poster integrates a little good natured humor and will serve to keep this serious subject more palatable. Finally, several techniques that have been employed to show support for the victims of verbal abuse will be offered as part of a tool kit.

Implications

Changes to minimize lateral violence and bullying need to be multi-dimensional, and must be implemented universally throughout organizations. Additional research in the area of organizational oppression and hostility toward individual members is needed to substantiate findings.

Learning objectives

1. Participants will be able to describe key factors that have created the current healthcare environment and seem to sustain rather than deter lateral violence between nurses.
2. Participants will be able to identify three interventions to stop lateral violence between colleagues grounded in the understanding of the interrelational evolution of healthcare organizational functioning.

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Integrating horizontal violence theory and concepts into the nursing curriculum

Poster

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Focus Education and Training

Abstract

Statistics from the International Council of Nurses (ICN) reveal that world wide nurses are three times more likely than any other service occupational group to experience violence in the workplace (Del Bel, 2003). One aspect of this violence is nurse to nurse directed abuse termed horizontal violence. This type of abuse can be collectively defined as dysfunctional behavior from one nurse to another that includes verbal abuse, passive aggression, and variable degrees of antagonism such as gossiping, innuendo, scape-goating, undermining, and intimidation (Baltimore, 2006). While not physically harmful, studies indicate that it can often result in reduced self esteem, sleep disorders, anxiety, hypertension, impaired personal relationships, disconnectedness, depression, and low morale (Smailes, 2003). Research indicates this type of abuse is found globally in all areas of nursing and affects not only individuals, but the entire health care system (AACN, 2007; Olive, 200 5; Smailes, 2003). Integrating horizontal violence theory and concepts into the nursing curriculum is the first step in reversing the problem of horizontal violence.

The importance of ethics and values education in nursing programs was affirmed in the American Association of Colleges of Nursing 1998 document Essentials of Baccalaureate Education for Professional Nursing Practice. Primary recommendations stemming from this report included preparing nurses professionally by giving them learning opportunities related to professional values to which professional behavior will be learned and lived (Eddy et al 1993). To follow, Duquette (2004) found that the acquisitions of professional values of nursing students were influenced by many factors. While formal lectures served as a knowledge base, the influence of practical experience in the healthcare setting and role-modelling by teachers and nurses provided the opportunity to see and apply professional expectations (Duquette, 2004).

As professional nursing practice evolves and changes new competencies must be developed and implemented on an on-going basis to meet the needs of nursing and the health-care system. This is evident as nurse educators struggle to develop cultural competencies in nursing students as the patient population as well as the student population becomes more diverse. Lack of cultural sensitivity and communication skills may lead to horizontal violence in the academic and clinical arena. The AACN (1997) reaffirmed its commitment to culturally competent care as follows:

- Schools must produce nurses capable of providing care that isindividual as well as population-based, culturally relevant, and focused on the whole person across the lifespan. Nursing knowledge should be globalized (AACN, 1997, para. 39).
- Utley-Smith (2004) conducted a cross-sectional survey of 363 nurse administrators from three health care settings and had them rate the importance of 45 nursing competencies. The need for an interpersonal communication competence scored in the top three in importance. The elements of this competency include: the ability to function as a participating team member; the ability to apply effective communication skills; and the ability to collaborate with other members of an interdisciplinary team (Utley-Smith, 2004).
- MacIntosh (2003) describes the need for students to have professional development throughout the curriculum in order to close the gap of earning respect, developing communication skills and incorporating reflection on and working to develop professionalism. This professional development should continue throughout an individuals nursing career to increase and maintain a knowledge base.

The issue of horizontal violence, as previously discussed, transcends all areas of nursing and has an enormous impact on individuals, patients and our economic structure. Nursing education is a logical method for providing possible solutions to the problem and potentially breaking the cycle of horizontal violence. As educators, we have the responsibility for developing students as competent nursing professionals capable of practice that includes ethical codes of behavior on which the practice of nursing have been developed. Educational preparation on the subjects of communication skills, self-assertiveness, cultural sensitivity, professional values and ethics, as well as the professional image of nursing should be mandatory (Ustun, 2006; Duquette, 2004; AACN, 1998; AACN, 1997). In addition students should receive education dealing with the dynamics and the effects of horizontal violence.

Proposed nursing curriculum model

The curriculum should be designed to include the necessary horizontal violence competencies identified by faculty and administration from the first semester and continue to build on them throughout the program with learning objectives that relate to the competencies. Nursing education can use creative teaching methods to include content throughout the curriculum that matches the goals and objectives of the overall nursing curriculum

and continue to include the concepts critical for horizontal violence education. Billings and Halstead (2005) discuss identifying important concepts core to nursing practice and threading them throughout the curriculum where faculty can develop learning experiences with different patient populations. For example, if students are in a pediatric rotation the curriculum could include communicating with parents and communicating with children along with the essential skills. Essential horizontal violence content can be placed in theory classes, sk ills labs, on-line teaching, or in the clinical setting.

Usten (2006) implemented communication competencies within learning modules in a four year nursing school in Turkey. Utilizing a problem-based learning curriculum, the goal of the program is to provide students with the skills necessary for self-communication, communicating with multidisciplinary teams, as well as with patients and family members. Students work within learning modules to identify what part of the curriculum is related to communication and adapt this as a learning topic. Communication skills related to that topic are then taught and practiced on a cognitive level (Usten, 2006). The students benefit from a communication skills lab to practice their communication skills related to the topic within each learning module such as role-playing and video-taping interactions.

The following proposed curriculum model illustrates how horizontal violence education can be threaded through a four semester nursing program utilizing Ustuns problem-based model, and the proposed learning objectives with teaching strategies from Table 2. Additional content can be added within the learning modules to the curriculum that reinforces the learning objectives and competencies of each learning module with the competencies of horizontal violence.

Table3
Proposed Horizontal Violence Curriculum Model
Semester Objective Learning Module Content Focus

1 1,2, 5 Medical surgical Basic communication skills
- Cultural sensitivity
- Horizontal violence education
- Professional image of nursing

2 3,5 Labor and delivery
- Pediatrics
- Communicating with families
- Communicating with children
- Communicating with peers
- Communicating with other health-care disciplines

3 4,5 Community health Communicating with other cultures
- Self-assertiveness training
- Nursing in a political climate
- The nurse as a change agent

4 4,5 Critical care
- Leadership Communicating with ICU patients
- Communicating in stressful situations
- Ethics in health-care

Role-modeling

Developing and implementing horizontal violence education throughout the curriculum is a necessary step in stopping the cycle of horizontal violence. The above models illustrate how learning objectives, competencies and curriculum development related to horizontal violence can be designed and threaded throughout a nursing program.

Curriculum and program evaluation

Evaluation of the proposed nursing curriculum must contain strategies to evaluate all the domains of learning. Special attention can be given to the higher levels of the cognitive domain which require an increased level of processing and critical thinking skills, and the affective domain which is concerned with emotional responses to phenomena (OConnor (2001). Since horizontal violence may occur in any situation from the clinical to the academic arena, it is important that the nursing student obtain the necessary critical thinking skills to stop the abuse from occurring. OConnor (2001) defines critical thinking as the transfer and application of knowledge and skills to a new situation (p.140). Teaching nursing students the concept of horizontal violence is just the first step in horizontal violence education. The ability to apply this knowledge and use it as a competent healthcare professional completes the final step.

Utilizing authentic assessment as an effective evaluation method presents students with real-world challenges with a full array of tasks that mirror nursing priorities (refer to Table 2). These challenges require them to apply their critical thinking skills and use self-evaluation practice (Wiggins, 1990). Authentic assessment incorporates

different methods to evaluate the high-level cognitive domain as well as the affective and psychomotor domains. Methods include; student portfolios, role-playing, simulation exercises, and journals (Billings & Halstead, 2005).

Student portfolio evaluation can occur anytime within a course providing formative evaluation during the course, and summative evaluation at the end of the course (Billings & Halstead, 2005). Elements required within the portfolios include; journal articles relating to horizontal violence, simulation exercises, reflection journaling, and written exercises. According to Smith (2005) reflective writing is considered a key component of portfolio assessment because it provides evidence of skills development and increasing clinical competence (p. 33).

Role-playing which evaluates the cognitive, affective, and psychomotor domains is an important evaluation strategy for providing formative feedback in the evaluation of communication skills and problem-solving (Billings & Halstead, 2005). Using this method, nurse educators can determine if the nursing student is grasping concepts, and if the student has the ability to put communication theory into practice. Video-taping which is a method of process recording can prove useful for evaluation of role-playing exercises (OConnor, 2001). Video-taping allows students to view how they responded to certain situations and discuss this in a safe environment with the nurse educator. This method of evaluation captures interpersonal interactions including non-verbal cues which are important in the context of horizontal violence education.

Evaluation of learning objectives, teaching strategies, and competencies play an important part in reversing the problem of horizontal violence. Through continual program evaluation, an effective curriculum can be developed that guides nurse educators in developing nursing professionals who are professionally responsible and competent in communication skills and the prevention of horizontal violence.

Recommendations for further research

It is evident from the literature review that there is little documentation on implementing solutions to reverse the problem of horizontal violence. Future research should include implementing and evaluating education programs for nursing students and post-degree nurses to determine what works best. Longitudinal studies using two cohorts of nursing students one with horizontal violence education threaded throughout the curriculum and one without could be followed for a period of time post-graduation to determine the impact education can have on professional development.

Further research on horizontal violence competency development and education for post-degree nurses should be conducted in clinical settings and in the academic environment. Additional research is recommended to explore includes how clinical staff mentors, faculty role models, and educational experience may facilitate professional development.

Learning objectives

- The participant will be able to define horizontal violence theory and concepts.
- The participant will learn how horizontal violence education can be integrated throughout nursing curriculum.

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Bullying among health care workers: From awareness to action

Paper

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Focus: Practice

Abstract

Bullying is one of the major challenge facing health care providers. It is a well known everyday occurrence among nurses. According to William Keating, a Norfolk district attorney, health care workers experience assaults at a four times higher than other industries, and for nurses and other health care providers, this rate jumps to 12 times higher.

In one study conducted among emergency department, 75% of the physicians stated that they had been threaten in the last year, and 28% had experienced at least one assault. Most literature showed that bullying has negative impact on employees productivity, job satisfaction, nursing retention and turn over.

This paper will discuss the types, consequences, and impact of bullying on nurses and patient care, and recommendation strategies for nurse mangers on how to deal with this negative phenomenon.

Learning objectives

1. To provide suggestions on diagnosis of the bullying within the organization and how to deal with it constructively
2. To provide suggestions for nursing administrators on how to diagnose, and handle bullying in workplace will be provided.

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Chapter 7 - Organizational/ hierarchical aggression/violence

Understanding organizational violence: The missing link in resolving workplace violence?

Paper

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Background and context

Initially much of the workplace violence (WPV) prevention and management responses focused on criminal violence from outside organizations. At the same time there was also a growing concern about service user violence on staff especially in the human services area. A later stage of this development was a growing recognition of relational violence at work. This includes staff-on-staff violence and aggression, bullying, horizontal violence, sexual harassment and domestic violence.

Models based on these areas of WPV have been developed by the International Labor Organisation (ILO), the World Health Organisation (WHO), the Injury Prevention Research Center (IPRC) and the California Occupational Safety and Health Administration (Cal/OSHA) and other regulatory bodies. This presentation will show that the current models and responses based on these types of WPV are inadequate and ineffective because they largely ignore the fact that organizational culture and management style have a direct contributory effect on the types of violence experienced by employees, third parties, and service users. The findings demonstrate that what at first appears to be criminal, service user or relational violence at work may in fact be the outcome of a type of 'upstream' organizational violence trickling down in a toxic way triggering further violence.

What is workplace violence?

Workplace violence is an unwanted *"perceived or actual verbal abuse, emotional threat, physical attack or misuse of power upon an individual's person or property, or against a work group or organisation while undertaking work related duties by another individual, group or organisation."* (Bowie 2002)

Most descriptions of workplace aggression and violence as applicable to human service workers include 3 types:
Type 1 external violence such as robbery, rape or random assault of staff,
Type 2 service user (patient/client/customer) or relative initiated violence,
Type 3 worker on worker aggression called horizontal violence or bullying.

To these three types I have added a fourth largely omitted by other typologies, Type 4 organisational violence. This typology of workplace violence is outlined in detail in Table 1.

Organizational Agression & Violence

Organizational violence involves *" .. organizations knowingly and unecessarily placing their workers or service users in dangerous or violent situations and or allowing a climate of verbal and physical abuse, bullying or harrasment to thrive in the workplace. Such a climate can also include the threat or reality of diminishing reseources, downsizing or layoffs."* (Bowie 2011 p. 47) Organizational violence may also spill over into surrounding communities or lead to attacks on other organizations through hostile takeovers or unethical competitive practices.

Table 1: Workplace violence typology

Type 1 External/Intrusive violence
- Criminal intent by strangers
- Terrorist acts including sabotage and kidnappings
- Protest violence
- Mental illness or drug related aggression
- Random violence

Type 2 Consumer related violence
- Consumer/clients/patients (and family) violence against staff
- Vicarious trauma to staff
- Staff violence against clients/consumers including terrorist acts

Type 3 Staff Related violence
- Staff on staff violence and bullying including terrorist acts
- Domestic violence and sexual harassment at work
- Third party violence

Type 4 Organisational violence
- Organisational violence against staff
- Organisational violence against consumers / clients / patients.
- Organisational violence against other organisations or communities
- Organizationally condoned or sponsored terrorist acts.

Bowie, Fisher & Cooper (2005)

This phenomena is referred to by a number of names including 'structural violence', 'systemic violence or abuse', 'institutional abuse / violence' or organisational violation. The focus in this presentation is on this neglected area, that of the interaction between organisational cultures, management styles and workplace violence.

Oppressive organizational cultures may come in many forms such as autocratic management, unreasonable work loads, takeovers, downsizing and retrenchments, reduced benefits and conditions or individual work contracts. Such violence prone organisations display certain characteristics which can include chronic worker / management conflict, an aggressive and authoritarian management style, inconsistent application of staff management policies, ineffective vertical and horizontal communication, inconsistent action and decisions by senior management, ineffective grievance procedures, perceived unjust treatment of employees, lack of mutual respect amongst separate work teams and departments, ethnic tensions, increased workloads with diminishing resources and rewards, poor working conditions and security. All of these generates a work culture that tolerates and stimulates occupational violence. Baron (1996) summarises many of these organisational characteristics in what he calls 14 corporate environmental factors that promote workplace violence. Such organisational characteristics are often a more accurate indicator of the potential for workplace violence than individual clinically focused attempts to 'predict' violence.

There is often a direct relationship between the amount of type 4 violence occurring within an organization and the level of external and internal service user and worker on worker bullying and violence experienced within that organization. The organization's functioning and setting can play a major part in effecting the levels and types of violence experienced within it.
Service user or staff aggression does not occur in a vacuum. Staff who are under organizational 'threat' may be lax with external security allowing violent intruders into the workplace (type 1 violence) or deal inappropriately with service users and their families (Type 2 violence) and are often aggressive with fellow staff (type 3 violence). In turn service users may become agitated and aggressive when cuts to services place their lives at risk. This is what I call the 'trickle down effect' of organizational violence. Such violence is often the direct result of the application of economic rationalist ideals and practices in the workplace and not just the result of 'individual pathology' of staff and service users. (Bowie 2011)

An increasingly important factor in the occurrence of violence is the environment generated by organisations undergoing rapid and ruthless change. It is common for human service organisations to be restructured several times over a very short time span placing the workers, their families and service users under intense and often unnecessary emotional and financial pressure. Those who *"buckle"* under this pressure by either leaving, becoming ill or indignantly asserting their rights are seen as weak or trouble makers. By blaming the staff in this way the organisations can ignore their role in creating a climate of suspicion, fear and anger that can lead to an increasingly violent workplace.

Another cause of concern is recent research showing that colleagues are often identified by assaulted staff as the major source of verbal and sometimes physical attack. Much of this bullying behaviour may be linked to organizational culture and change. This phenomenon is referred to as horizontal violence, bullying or mobbing. (Bowie 2011)

Responses to Workplace Violence

Effective violence prevention and defusion within organisations requires a multi faceted and integrated approach which takes into account individual, contextual and organisational variables. Positive management techniques involving improving the quality of staff, changing or establishing a non violent culture, implementing and modifying systems, adjusting leadership and developing policies may help minimize workplace violence and crime. (Bowen, Privitra & Bowie 2012)
Many earlier responses to workplace violence by employers attempted to deflect attention from a potential key contributor to workplace violence, that is, the ways organisations are structured and managed. Such attempts included 'target hardening', ‹psychological profiling' to identify remove potentially violent staff and clients, the provision of violence management training as well as critical incident debriefing (CISD) to help staff. (Bowie 2002) More recently risk management and zero tolerance approaches have become more 'popular.' Table 2 lists a number of these management responses and summarises some of the dangers and shortcomings of such approaches

Additional risk management responses by management included comprehensive aggression management procedures and policy manuals, increasing physical security, duress alarms, more employee assistance programs (EAPs), conflict resolution processes, stress management techniques and risk management etc.
Comprehensive aggression management procedures and policy manuals are only of value if they are backed by an organisational commitment to their use and are accompanied by sufficient resources for their implementation. EAPs are only as effective as they are allowed to be by their organizational structure and management and their use of mediation in workplace violence situations can increase the trauma for the 'target'.
More employee assistance programs, conflict resolution processes and stress management techniques, useful as they may be, also serve to deflect attention from the abusive organisational structures and cultures that may create such conflict and aggression. While such responses may sometimes be necessary it could be suggested that they only tinkering at the edges of the problem and again focus largely on the worker and ignore the organisational, economic and social context in which violence is appearing. (Paterson et al 2010) Braverman (2000 p. 29) supports a comprehensive approach to workplace violence stating that *"(t)he issue of workplace violence really asks us to look at what kind of human environments we are creating in our workplaces."*

Thus more recently approaches to the ‹prediction› and prevention of workplace violence have tended to focus more on the characteristics of work teams and organisations that may make them more violence prone rather than the individual 'pathology' of the particular offender or the skill shortcomings of staff. Such organisational characteristics are, mentioned by Baron (1996), often are a more accurate indicator of the potential for workplace violence than individual focused strategies.

Table 2: Management responses to workplace violence

'Target hardening' (CPTED)
- May cause displacement of violence elsewhere
- May make aggressor more determined
- Systems may fail
- Staff may feel trapped

'Psychological' profiling
- Not based on normal populations
- Impact of organisational climate not accounted for
- May infringe civil liberties / human rights / discrimination legislation

Provision of violence management training
- Training may shift blame to workers
- May be ineffectual (one size does not fit all)
- Organisation may sabotage training impacts

Critical incident debriefing (CISD)
- Growth industry
- Debate over its effectiveness

Risk management procedures
- Mechanical approach to human issues
- Zero tolerance used to stifle genuine complaint
- May be ineffective with 'internal' violence

Conflict resolution /mediation
- May identify the worker as the 'problem'

Stress management techniques
- 'May be a band aid approach'
- Deny organizational stressors

Adapted from Bowie 2002

However even where there is a recognition of the role organizational governance and structures can play in stimulating workplace violence the current responses are often inadequate and sometimes destructive as Braverman (2000 p.29) comments.

"The standard tools and methods applied by employers and labor organizations to deal with issues of occupational health and safety and discipline are inadequate and inappropriate in responding to the problem of workplace violence. In fact, the methods and approaches commonly in use to handle more commonplace performance, health and behavior problems actually worsen the problem when applied to cases of violence or threat. He further observes "(t)his is because employers do not consider the sources of stress leading to a climate of violence or hostility in their workplaces, or do not attempt to confront the system deficiencies that allow violence or threats to go undetected."

Conclusion and implications

The implications for WPV and safety practice of this presentation are that the current ineffectual or damaging approaches focusing on personal pathology need to include an organizational perspective. Similarly in the WPV research area there must be a more in-depth investigation of how organizations can become toxic and in turn trigger violence further down the line. Education and training practises in turn must foster a greater awareness of this toxic interaction and provide comprehensive skills to identify and deal with such issues. The final and greatest challenge is for organizations themselves to identify the potential for trickle down WPV and to build in ethical management practices, policies and procedures to prevent this happening. These findings have implications for how WPV issues are managed in healthcare and human services organizations nationally and internationally.

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Learning objectives

1. Participants will learn that current responses to WPV management and prevention focusing largely on individual behaviour are ineffectual or even damaging and need to include an organizational perspective.

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Are paramedic and midwifery students exposed to workplace violence during clinical placements?

Paper

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Focus: Education and Training
Keywords: Violence, student, paramedic, workplace, hospital, midwife.

Background

Anecdotally, we know that paramedic and midwifery students will not report, in writing, acts of workplace violence during clinical placements as they do not want to jeopardise their opportunity of getting a job with the respective employer. In turn, the ambulance service and hospitals will not act upon reported workplace violence that occurred during the clinical placement unless it is in writing.

Internationally, no study has been published that has investigated the exposure rate of undergraduate paramedic students to all types of workplace violence. There has been two studies into midwifery student workplace violence, a Turkish study into midwifery student responses to verbal abuse and their subsequent response, but due to the study type, a phenomenological study, no exposure rates were reported.(1) The second was a study in the UK which looked at the exposure of midwifery students to workplace bullying.(2)

This research sought to identify the magnitude of workplace violence to undergraduate paramedic and midwifery students during clinical placements. Therefore, the aim of this study was to identify the type of workplace violence experienced by undergraduate paramedic and midwifery students and their response to the violence.

Methods

Study design

The study used a cross-sectional methodology in the form of a paper-based questionnaire to elicit undergraduate paramedic and midwife responses to workplace violence whilst on clinical placements.

Definitions

We defined workplace violence as violence that was associated with working during the clinical placement. As such, it included violence that occurred in the ambulance station or hospital, offices where management was housed, the ambulance itself, any ward or room attached to the hospital, any other healthcare facility, and for the paramedic students the incident/case location.

Workplace violence perpetrators included, but were not limited to, other paramedic/midwifery/medical staff (including all management levels), patients, patients' relatives or friends, incident bystanders, other emergency service staff (fire & police), and other healthcare facility staff.

Participants

The study involved students enrolled in the Bachelor of Emergency Health (Paramedic) [BEH], Bachelor of Emergency Health (Paramedic)/Bachelor of Nursing (BEH/BN), and Bachelor of Midwifery (BMid) courses at Monash University Peninsula Campus.

The students available for inclusion into the study are listed in Table 2. Second year BEH students were not included as they did not undertake any clinical placements during the first two semesters of 2011.

The third year of the BEH/BN undertake the same clinical placements as first year BEH students with fourth year BEH/BN students undertaking the same placements as third year BEH students.

Table 1: Student numbers by course by year

Course	Year 1	Year 2	Year 3	Year 4	Total students enrolled
Emergency Health (Paramedic)	65	N/A	67	N/A	132
Nursing/ Emergency Health (Paramedic)	34	47	41	36	158
Midwifery	27	28	48	N/A	103

Legend: N/A = Not Applicable

A convenience sample of students was used to establish incidents rates for further study.

Instrument

We utilised an existing questionnaire, the Paramedic Workplace Violence Exposure Questionnaire (PWVEQ). (3) The PWVEQ consisted of five sections. The first section covered general demographic information; the second covered six forms of workplace violence - verbal abuse, property damage or theft, intimidation, physical abuse, sexual harassment, and sexual assault; the third covered how the person felt personally after experiencing an episode of violence; the fourth covered the response to the violent incident(s); and the final section covered the impact of the violence.

The PWVEQ has been used previously in a study with paramedics and has demonstrated face and content validity.

Procedure

All participating students received an explanatory statement about the study and were informed participation was voluntary and anonymous prior to commencing the survey. The questionnaire was administered at the end of a lecture for each group and each year of the courses. Consent was implied by completion and submission of the anonymous survey.

Data analysis

Data analysis was undertaken using SPSS (Statistical Package for the Social Sciences Version 19.0.0.1, SPSS Inc, Chicago, Illinois, USA). Descriptive statistics are used to summarise the data, with inferential statistics used to compare groups (year levels and gender) using a two-tailed t-test or Analysis of Variance (ANOVA) with post hoc tests where indicated. All results are two-tailed unless otherwise stated. The results will be considered significant if the p value is <0.05, all confidence intervals (CI) are 95%.

Ethics

Ethics approval for the study was granted by the Monash University Human Research Ethics Committee (MUHREC).

Results

There was a total of 393 students eligible to participate in the study with BEH n=132 (33.6%), BEH/BN n=158 (40.2%) and BMid n=103(26.2%) students. There was a response rate for BEH, BEH/BN and BMid students of n=60 (45%), n=24 (15%) and n=52(50%) respectively.

Overall there were n=29 (21.3%) males and n=107 (78.7%) females. There were n=24 (40%) males and n=36 (60%) females in the BEH group, n=5 (20.8%) males and n=19 (79.2%) females in the BEH/BN group, and n=52 (100%) females in the BMid group.

The average age of all students was 26 years, median age of 23 years. For the BEH group mean age was 24.7 years, median age 23 years, BEH/BN group, mean age was 23.5 years, median age 22 years, and BMid group mean age was 28.7 years, median age 25.5 years. Most students were from the paramedic course with a small number of students from the paramedic/nursing and midwifery course as outlined in Table 2.

The majority of students were in third year with the fourth year students from the BEH/BN course, see Table 3.

Table 2: Study participants by course

Course	n(%)
Bachelor of Emergency Health (Paramedic)	60(45)
Bachelor of Emergency Health (Paramedic)/Bachelor of Nursing	24(15)
Bachelor of Midwifery	52(50)

Table 3: Study participants by course by year

Course	Year 1 n (%)	Year 2 n (%)	Year 3 n (%)	Year 4 n (%)	Total n
Emergency Health (Paramedic)	21(35)	N/A	39(65)	N/A	60
Nursing/ Emergency Health (Paramedic)	0	0	0	24(100)	24
Midwifery	21(15)	21(15)	69(52)	N/A	52

Table 4 demonstrates that the most common form of violence experienced by students overall was verbal abuse followed by intimidation and property damage/theft. There were a small number of sexual harassment incidence, and no incidence of sexual assault. The only statistically significant results were the comparison between paramedic and midwifery students who experienced property damage/theft and intimidation, all other

comparisons between paramedic and midwifery students were not statistically significant. These results indicate that midwifery students experienced more acts of violence during their clinical placement compared to the paramedic students.

Table 4: Number of students who experienced each type of violence during their last clinical placement

	Overall n	Paramedic Students (n=84) n(%)	Midwifery Students (n=52) n(%)	Difference between Paramedic and Midwifery Students
Verbal abuse	24	16(66.7)	8 (83.3)	t=0.572 CI -0.096 to 0.174 p=0.568
Property damage/theft	5	0 (0)	5 (100)	t=-2.329 CI -0.179 to -0.013 p=0.024
Intimidation	23	7 (30.4)	16 (69.6)	t=-3.143 CI -0.367 to -0.082 p=0.002
Physical Abuse	1	1 (100)	0 (0)	t=0.763 CI -0.019 to 0.043 p=0.447
Sexual Harassment	4	1 (25)	3 (75)	t=-1.318 CI -0.115 to 0.024 p=0.192
Sexual Assault	0	0 (0)	0 (0)	

Of the students surveyed 32% had experienced at least one form of violence associated with the previous clinical placement, with 81% being females.

The results in Table 5 demonstrate that more female than male students experienced property damage/theft and sexual harassment. All other comparisons between male and female students were not statistically significant.

Most students indicated there were multiple perpetrators during the incident that worried them most. In most types of violence it was the patient or one of their immediate relatives or friends followed by another professional or colleague, see Table 6.

Table 5: Students experiencing violence by gender

	Female Students (n=107)	Male Students (n=29)	Difference between Female and Male Students
Verbal abuse	18 (75%)	6 (25%)	t=-0.46 CI -0.197 to 0.122 p=0.646
Property Damage/Theft	5 (100%)	0 (0%)	t=2.279 CI 0.006 to 0.087 p=0.025
Intimidation	19 (82.6%)	4 (17.4%)	t=0.502 CI -0.117 to 0.196 p=0.617
Physical Abuse	1 (100%)	0 (0%)	t=0.527 CI -0.027 to 0.046 p=0.599
Sexual Harassment	4 (100%)	0 (0%)	t=2.029 CI 0.001 to 0.074 p=0.045
Sexual Assault	0 (0%)	0 (0%)	

Table 6: Main perpetrators of violence according to type of violence experienced

	Patient/client %	Patient's/client's families, relatives, companions or friend %	Other professional or colleague %	Bystander %	Patient and relative%
Verbal abuse	50	8.4	20.8	-	20.8
Property damage or theft	-	-	20.0	40.0	40.0
Intimidation	19.0	14.3	61.9	-	4.8
Physical abuse	100	-	-	-	-
Sexual harassment	-	25.0	75.0	-	-
Sexual assault	-	-	-	-	-

Table 7 displays the gender of the main perpetrator(s) of the violence with the gender of the perpetrator most often male.

Table 7: Gender of the perpetrator by violence type

	Male %	Female %	Both %
Verbal abuse	33.3	29.2	37.5
Property damage or theft	50	-	50
Intimidation	28.6	42.9	28.6
Physical abuse	100	-	-
Sexual harassment	100	-	-
Sexual assault	-	-	-

The level of fear experienced during the incident varied according to the type of violence experienced, see Table 8. Those experiencing verbal abuse or intimidation were generally mildly or quite apprehensive whereas the majority of those who had been subjected to property damage or theft were mildly apprehensive. People who experienced physical abuse were generally quite apprehensive with those experiencing sexual harassment had no fear or were mildly apprehensive.

Table 8: Level of fear experienced during the violence episode

	None %	Mildly apprehensive %	Quite apprehensive %	Frightened %	Very frightened %
Verbal abuse	16.7	50	25	8.3	-
Property damage or theft	40	60	-	-	-
Intimidation	18.2	40.9	36.4	4.5	-
Physical abuse	-	-	100	-	-
Sexual harassment	50	50	-	-	-
Sexual assault	-	-	-	-	-

The student's immediate response to the violent episode varied across the violence types from doing nothing to notifying the police. Common responses to verbal abuse included doing nothing, staying calm, trying to diffuse the situation, or trying to reason with the person, followed by talking to the police. The common response for property damage or theft was doing nothing, confronting the person and notifying the person in charge. There was a wide range of responses to intimidation including doing nothing, calling or talking to the police, attempting to diffuse the situation, and notifying a supervisor. For physical abuse, the most common response was to notify a supervisor. When the nursing/paramedic student was exposed to sexual harassment, the response was to do nothing.

A common factor believed to have precipitated many of the violence incidents was alcohol use. Drugs, service dissatisfaction and psychological or mental health problems were also factors cited commonly as having precipitated the violence.

In terms of responses to violence, students were also asked to indicate the degree to which they performed certain actions after a violent incident occurred. These responses are displayed in Table 9. Very few students took days off from the clinical placement, sought medical attention or received professional debriefing or counselling. The majority of students said they always, often or sometimes discussed the incident with other students or a supervisor/mentor and with family and/or friends.

Table 9: Frequency in which students responded in a particular way after the violence occurred

	Never %	Once %	Sometimes %	Often %	Always %
Did nothing	50	21.4	28.6	-	-
Discussed with family and/or friends	6.7	6.7	-	53.3	33.3
Discussed with other students	6.7	13.3	13.3	20.0	46.7
Discussed with supervisor/mentor	7.7	15.4	23.1	15.4	38.5
Received professional debriefing/counselling	85.7	-	7.1	-	7.1
Completed and incident report	78.6	7.1	7.1	7.1	-
Took days off work	92.9	-	7.1	-	-
Took on a different role	92.9	7.1	-	-	-
Sought medical attention	92.9	7.1	-	-	-

Conclusion

The results of this study demonstrate that undergraduate paramedic and midwifery students are exposed to acts of violence when undertaking their clinical placement. The findings suggest there needs to be an anonymous reporting system for students who experience acts of workplace violence whilst attending clinical placements. The establishment of an anonymous reporting system may encourage students to report the violent acts and not *"do nothing"* about it. These results also highlight a need for student education prior to attending the clinical placement about how to deal and cope with workplace violence. There is a need for additional studies to determine the reasons for students not reporting the violence and the actual affect the violence has on the student.

Acknowledgements

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Learning objectives

1. Students are exposed to acts of workplace violence during their clinical placements and hence need to be educated on how to deal with the incident.
2. A process needs to be put in place so students will freely report incidents of workplace violence.

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Blame it on the nurse! Structural violence in healthcare

Paper

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Focus: Education and Training
Keywords: Healthcare, structural violence, cultural violence, direct violence, nursing, medical hierarchy

Abstract

The application of Johan Galtung's theory of structural violence to the rules dictated by culture or society in the healthcare field can explain: The unequal distribution of resources and power between healthcare providers, the varying impacts on tolerance or thresholds for adverse effect, gender inequities, and the lack of consequences for some of the associated behaviors of verbal abuse, intimidation, threats, exclusion, and discouragement. Structural violence is legitimized by society, hospital administration, and the system. Structural violence in the medical hierarchy reinforces miscommunication, increases conflicts, and impacts patient mortality. By analyzing and understanding the basic human needs of individuals or a group through this theory, institutions or structures can adapt and meet those needs, thus decreasing structural violence.
The professional cultures of medicine have long been influenced by socialization, education, gender, and a medical hierarchy. Just as we look at patients in a comprehensive manner, horizontal or lateral violence cannot be separated from the healthcare system as a whole. Structural violence is perpetuated by the system and the healthcare hierarchy. This violence cannot be seen in a physical sense but can be displayed in unequal power or unequal choices (Galtung, 1969). Structural violence also encompasses cultural violence which may deny the satisfaction of basic human needs due to conformity and legitimization of certain acts (Galtung, 1969).

This paper intends to define and discuss the relationship between structural violence as it compares to direct violence and cultural violence. An example of structural violence will be discussed. The purpose of recognizing and understanding this theory and possible contributions to conflict analysis will also be explored. This will be done to bring about an understanding of structural violence to assist in the de-escalation of certain conflicts.

Structural Violence

Structural violence theory, also defined as structuralism, is a psychosocial based theory developed by Johan Galtung. According to Rupesinghe and Correa (1994), Galtung's' theory is based on basic human needs or the lack of meeting these needs. He identified conflict as being like a contagious disease. No one wants to touch it. It is both complex and difficult to treat. Like in health care, there is a need to look at the victim and not the disease itself. Applying this analogy to Galtung's theory, by reframing the conflict from the view of the oppressed and the exploited, allows one to appreciate this perspective. It is the structure of the system that impacts the *"patient"* and their rights to basic human needs (Rupesinghe & Correa, 1994).

The definition of violence according to Galtung (as cited in Rupesinghe & Correa, 1994, chap. 2, para. 1), is that *"violence is present when human beings are being influenced so that their actual somatic and mental realizations are below their potential realizations."* There are specific rules to follow in regards to human behavior. These rules are dictated by culture or society as a whole. These rules are what direct your interpersonal relations (Rupesinghe & Correa, 1994). In this respect, it is external pressures from following these rules that assist in developing this violence.

The ability for each person to deal with these pressures may be different. Therefore, a persons' tolerance or threshold for adverse effects will alter the final outcome or performance. This, in turn, will affect the impact of the structural violence. The goal of individual societies may be measured at different levels or degrees. One society may accept minimal improvements while others may not. What must be remembered about this theory of violence is that the victim shares the rules determined by the structure. He/she is part of the system; otherwise he/she would not be affected (Galtung, 1969; Rupesinghe & Correa, 1994).
In structural violence there is an unequal distribution of resources or an inability in some way to obtain these resources. These inabilities could stem from lack of education to know how to access these resources, lack of socioeconomic funds to access these resources, and/or a perceived low level of power. Structural violence begins within a social system and insidiously and inadvertently affects someone interpersonally. It is not person to person. In structural violence, the violence cannot be traced back to a specific person but displays itself as unequal power or unequal choices (Galtung, 1969; Rupesinghe & Correa, 1994).

Direct Violence

Structural violence contrasts with direct violence as direct violence deals with a specific person or perpetrator which can be identified. Face to face violence or the use of physical force is an example of direct violence. The victim can identify the assailant (Rupesinghe & Correa, 1994). According to Galtung (1990), direct violence is

an event. It is evidenced by force, the threat of force, or coercion. He says that direct violence lies at the top level or strata of the triangle. The next level or strata is the structural violence strata and then finally, the cultural violence stratum is at the bottom.

Cultural Violence

Galtung (1990, p. 294) describes the strata further by stating that *"cultural violence at the bottom is the steady flow through time, a substratum from which the other two can derive their nutrients."* According to Galtung (19690), the definition of cultural violence is the denial of a specific culture to allow the ability to maintain or establish an identity, security, or symbolic meaning to satisfy human needs. Cultural violence occurs when these traditions and identities are challenged. Cultural violence can also legitimize direct and structural violence (Galtung, 1990). Culture advocates violence to maintain homogeneity and preserve the culture. These beliefs are passed on from generation to generation by enculturation and socialization (Rupesinghe & Correa, 1994).

Multiple realities manage to promote differences in meanings from one person to the other (Augsburger, 1992). In doing so, conflict evolves and confusion and misunderstanding may erupt. This concept can be applied to the subject of medicine and the management of patient care. It is important for the physician and nurse to understand that their cultural experiences assist in formulating their interpretations of each other's behavior and its effect on themselves (Docherty, 2004).

The definition of their own medical professional identity by socialization and education has influenced the formation of a silo effect that impacts the physician and nurses' individual worldviews in practice. This silo effect is further defined through the specific cognitive and learning skills assumed to be required for the respective profession (Hall, 2005). Admission to schools is based on these abilities and the silo is perpetuated. Physicians are educated in an independent, highly competitive manner and nurses are educated in a teamwork environment, relaying information to team members and maintaining open channels of communication from one shift to the next (Hall, 2005).

Application and Relationship of Structural Violence to Healthcare Hierarchy

An example of the application of the structural violence theory that leads to inadvertent injuries and, at times, death is generated from the failure of healthcare systems to effectively deal with the poor communication between physicians and nurses. According to the United States Department of Labor (2008) statistics, women make up 92% of the nursing workforce. The most recent gender statistics for physicians, available from the American Medical Association (2011), show that male physicians make up 72.2% of the physician population. This significant difference in gender between the two professions may be part of the conflict.

The structural violence theory applies to this structure as evidenced by the following statistics: Miscommunication between physicians and nurses is responsible for 37% of all errors in healthcare and most significantly associated with excess hospital deaths (Manojlovich, 2007). The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as cited in Rice-Simpson, James, & Knox (2006, p. 547), states that *"communication failures are the leading cause of preventable patient injuries and death"*.

There are different cultures noted in healthcare. One culture is medicine and another culture is nursing. The differing cultures between the professions are due to their backgrounds, training, values, and beliefs of medicine and patient care (Woodard & House, 1997). According to Robinson et al (2010), this is because their education is in a distinct and separate format where no courses are shared. Following this *"silo"* effect of education does not allow for the development of recognition or understanding for each others' unique profession. Mannahan (2010) agrees that there are differences in the approach to practice and this may lead to conflicts in their working relationships.

Physician training is responsible for a specific socialization. This socialization promotes the medical professional culture which does not include nurses. The behaviors induced by this culture are those of detachment, self interest, and entitlement which do not promote collaboration between physicians and nurses (Whitehead, 2007).

This communication difference is also due to the placement of the physician in a hierarchal and patriarchal position. This provides a dominant position over the nurse and places the nurse in a subservient and inferior role. The physicians' perception is that he is the ultimate authority (Wanzer, Wojtaszcyk, & Kelly, 2011). This perceived authority gradient affects patient care. Reports to this effect have been well documented. According to Cosby and Croskerry (2004), significant interpersonal conflicts erupt during training and result in hesitancy for one to speak up if there is a difference of opinion, for fear of being wrong. In the context of healthcare, this could have a fatal result. Cosby et al (2004), apply this to the reverse of nurse-physician communication as well. If the nurse perceives her role as inferior and hesitates to bring up a patient issue for fear of retaliation, condescending remarks, or verbal abuse, it can result in a medical error and potentially death for the patient.

Recognition of the problem is one of the first ways to begin to deal with discourse and end the systematic structural violence flow. There is a lack of evidence in the literature that physicians show an awareness that this communication discourse even exists. This may be due to a disinterest as well (Weeks 2004). Differences in perception of nurse competence by physicians, disrespect of nurses from physicians, and differences in

awareness of scope of practice and regulatory requirements between physicians and nurses has led to these barriers and discourse (Cadogan, Franzi, Osterwell and Hill, 1999).

Manojlovich (2005) reports nurses express significant job satisfaction when certain factors in their work environment are met. These factors that lead to job satisfaction also indirectly lead to reports of improved communication between physicians and nurses (Manojlovich, 2005). Conversely, dissatisfaction with the job and the consequence of poor communication can cause feelings of hopelessness and frustration which is expressed as apathy or withdrawal (Galtung, 1990). A reaction to this deprivation of needs could also be direct violence, perhaps by the nurse towards self or others (Galtung, 1990).

Some of these differences reported, reflect the separation of education and training that the professions should address. Understanding the differences in professional cultures is necessary to promote collaboration and proper communication between the two professions. The nursing profession has varying degrees of education and because of this, finds it difficult to unify as one profession (Bruder, 2001). This could be defined with the term *"fragmentation"*. According to Galtung (1990), fragmentation is defined as keeping a group from uniting, or forming a united front. The fact that this varying level of education has not changed despite attempts through legislation has served to keep them in their place and avoid the development of power to effect further change. The voice of nursing has not been heard and therefore is under-represented and oppressed both locally and politically (Christie, 1997).

Galtung (1990) describes a causal flow between cultural violence, structural violence, and direct violence. He mentions that these concepts form a triangle where any corner of the triangle could instigate violence. The triangle can also be divided into strata where each type of violence impacts the other.

The tradition of the hierarchal society is an important concept to explore to increase understanding of the medical model of physician education and hospital administration. Augsburger (1992, p. 244) supports the fact that in a traditional hierarchy there is a *"concord of uniformity"* which encourages a suppression of behaviors or actions that do not conform to the tradition and would threaten the sanctity of the hierarchy. The institution promotes the patriarchal hierarchal structure in a negative conflict cycle which serves to limit the opportunities for the nurse to express any inequalities she perceives.

According to Bem (1993) the assigned professional gender role, under the patriarchal hierarchy, constrains and coerces the individual to conform and restricts their ability to promote change. Thus, denying the nurse any power to make changes that may benefit the institution from a female perspective. This patriarchal institutional hierarchy continues to define relationships and dictate the approved behaviors, norms, morals, and values according to outdated gender roles (Augsburger, 1992). The relationships theoretically, are defined in part, through institutional gender construction and enculturation historically programmed through daily social experiences (in education and professional culture) in order to organize their professional social reality (Bem, 1993). This concept also consists of situating an individual into a social context that will shape the person into what is expected by their respective medical profession.

The above example starts with the perpetuation of a patriarchal top down, definition of the levels of responsibility in healthcare. The physician has been trained, historically, to run the healthcare show (Center for American Nurses, 2008). This shows that this example could have started on the structural violence point.

The *"God complex"* taught in medical school and instilled in training reinforces these behaviors. Early nursing training reinforced the subordinate role of the nurse to the physician by calling them *"the physician's handmaiden"* (Center for American Nurses, 2008, p. 2). The use of intimidation and verbal abuse from physicians as well as patients, families and supervisors leads to vulnerability, feelings of powerlessness and an acquiescence as described from a victim perspective (Center for American Nurses, 2008). Society is uneducated and misinformed as to the roles of both professions and they continue to subscribe to these historical definitions and these points lead to cultural violence in relation to the profession.

The direct violence occurs as an adverse reaction to the pressures within the structural violence and cultural violence. The amount of pressure an individual can handle varies but can be influenced by his/her culture (Rupesinghe & Correa, 1994). Cultural violence also has the ability to legitimize behaviors that may not be just outside of the culture (Galtung, 1990).

Understanding Structural Violence, De-escalation of Conflict, and the Purpose this Concept Serves in Conflict Resolution

Identification and the satisfaction of identity and security needs can be directed in positive, peace keeping ways. Preventative approaches can include methods to remove the cause of the event which causes conflict. Behavior control could be one that would apply to the example given in this paper (Christie, 1997).

In order for the de-escalation to remain in effect, the interventions have to go beyond the individual and serve to be curative within the entire structure. The needs of the individual, the structure, and the culture must be addressed simultaneously in order to sustain the reduction of violence. If this is not done the violence will return (Christie, 1997). Galtung (1990, p. 302), asserts that working on all three corners simultaneously could develop a *"virtuous triangle rather than a vicious triangle, also self reinforcing"*. Never assume one point will lead to a change in the other (Galtung, 1990).

By analyzing and understanding the basic human needs of the individuals or the group, institutions or structures can adapt and meet those needs. The entry point of handling the conflict will not have to be during an escalating event. This allows a re-building of the structure and the ability to identify where conflict may occur in the future (Christie, 1997).

In relation to the field of conflict resolution, the theory of structural violence, cultural violence, and direct violence can enlighten the practitioner. The analysis, methods and approaches that are utilized to discern and diffuse the conflict will allow for a more sustainable resolution. These methods should be taught to the individuals, culture, and the structures' principle players to allow self resolution (Leech, n.d.).

Conclusion

The importance of understanding what is significant in the causes of structural violence lends itself to the ability to transform the structure. The consequences of these changes must also be understood. If not understood, the structure that causes the violence will remain without a comprehensive understanding and the violence will be perpetuated by those who participate (Rupesinghe & Correa, 1994). The importance of developing strategies in relation to the total context of the violence is imperative.

Identification of the professional cultural differences between physicians and nurses can assist in the integration of knowledge about their respective professional practices, beginning with education at the pre-licensure level and continued through their professional careers. Developing a deeper understanding of the others professional culture, their beliefs, values, and shared patterns can lead to a reduction in miscommunication, medical errors, and an improved work environment. This knowledge will lead to a proposal for policy guidance and an introduction of a best practice initiative for a communication and conflict engagement program for all healthcare workers and administration. This program may be initiated during orientation and/or through required continuing education requirements. It is a step in a positive direction to break the cycle of structural violence. Further research on the implications of structural violence, specific to healthcare and the professional cultures is warranted.

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Learning Objectives:

1. Distinguish the meaning of structural violence from other forms of violence.
2. Identify manifestations of structural violence and their impact on today's healthcare environment.
3. Evaluate best practice initiatives that may assist in decreasing structural violence in today's healthcare environment.

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Experience and effects of offensive behaviours among Ontario Nurses Association Health and Safety Representatives

Poster

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Focus: Research

Background

The Ontario Nurses Association (ONA) participated in the Mental Injuries Tool Group which is a collection of representatives from various unions, academics and health and safety (H&S) organizations who wanted to develop a shop-floor tool to measure the impact of stress in the workplace.

Method

The survey instrument selected for this purpose was the Copenhagen Psychosocial Questionnaire (COPSOQ). In order to pilot test the feasibility of this survey instrument, ONA asked 273 registrants for their union H&S workshops to fill out the survey online before attending the meetings in May 2012. The frequencies of the responses were compared to published reference data derived from a population survey in Denmark. Furthermore, univariate correlations were calculated to determine if risk factors were associated with 5 symptom scores.

Findings

The rates of offensive behaviours (undesired sexual attention, threats of physical violence, physical violence and bullying) reported by ONA H&S representatives were 5-12 times higher than among the corresponding rates among the Danish reference population. Symptoms also were reported at higher rates. Threats of violence and bullying were among the risk factors that were significantly ($p<0.05$) associated with the symptom scores. A more in-depth evaluation showed that bullying from superiors and subordinates had a greater association with symptom scores than did the more frequently reported bullying from colleagues.

Conclusions

ONA H&S representatives reported very high rates of experiencing offensive behaviours in the workplace. These experiences reported were associated with increased symptom scores as measured by the COPSOQ survey. While colleagues were the most frequently reported source of bullying, this analysis indicates that among ONA H&S leaders bullying from other sources (superiors and subordinates) are associated with more symptoms than bullying from colleagues.

Implications for practice

Based on these findings, ONA plans to make the survey tool available to ONA members to use to identify work units where offensive behaviours generate stress symptoms among workers. Evidence gathered from individual unit surveys will be shared with local joint health and safety committees to assist in developing site specific strategies and recommendations for local response to identified problems. Survey data will be aggregated on a provincial sector/unit basis to identify trends meriting broader provincial response and strategies such as collaborative health and safety initiatives, collective bargaining, etc.

Learning objectives

1. To demonstrate that the COPSOQ appears to be a useful shop-floor tool to identify and measure workplace psychosocial stressors such as violence/harassment/bullying and their impact on worker health.
2. To demonstrate that the impact of bullying can depend on source of that stressor e.g. superiors and subordinates vs colleagues.

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Indigenous public health in Brazil: Correlations between clinical and political violence

Paper

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Focus: Policy
Keywords: Indigenous health, care, tutelage, citizenship, violence

Introduction

Focusing on the observed relationships that characterize violence, this article approaches research developed by authors on public policy regarding the health of indigenous people in Brazil. Using analysis articulated between, on the one hand, the fieldwork addressing primary health services in indigenous areas and, on the other, observations of policy negotiations between indigenous leaders and governmental managers in the health field, this discussion highlights the existence of two types of violence. The first type refers to the frequent symbolic violence observed in the day-to-day interactions between healthcare workers and indigenous patients; the second consists of the disjunction between the official political rhetoric of the recognition of indigenous authority and the systematic non-consideration of practical decisions for indigenous health.

From this perspective, the text takes the following course: (i) it defines the concept of violence; (ii) it presents ethnographic examples of two types of violence in indigenous health, i.e., in the day-to-day care of indigenous people and the negotiations of indigenous health policy; (iii) it contextualizes these violent interactions in relation to the configuration of values specific to *"care"* that characterize the basic healthcare provided to the indigenous, as well as to *"tutelage"* in the relations between the indigenous and the surrounding national society; and, finally, (iv) it attempts to trace connections of mutual support between both configurations and the specific forms of violence that they engender, inserting these connections into the larger context of the construction of indigenous citizenship debate in Brazil.

Violence as a type of interaction

Perhaps one of the greatest challenges of managing the concept of violence in different cultural contexts is to break the dichotomy between, on the one hand, its definition exclusively from representations constructed by research subjects and, on the other hand, its reduction to elements that can be universalized to all sociocultural formations. In the first alternative, the comparative approach so dear to anthropological understanding (and to scientific undertakings) remains infeasible; in the second, in the face of diversity, it falls to the investigator to establish which local elements should compose a public catalogue for all humanity, in an unproductive exercise of authority.

Thus, to break the dilemma between the radical relativism of the impossibility of translation between worlds and the ethnocentric universalism of empirical universals, one must change the guiding question of the investigation toward the phenomena of violence by no longer considering what content defines them, but instead considering the characteristics that qualify a form of interaction as violent. By this displacement, violence ceases to be a substantive reality and transforms into a social interaction in which direction and strategy are anticipated, manipulated and disputed. Consequently, violence comes to be considered a resource in the construction of legitimacy (Krohn-Hansen 1994:370) among those involved in dispute in a particular context that violates the physical and/or moral integrity of the other. However, because the aggressor intends, to some degree, to recognize the validity of his action, violence is a relationship of power that is composed of a triad; the third participant, who must be convinced of the righteousness of the act in question is as important as the two interacting participants, the violent actor and the victim. This third element can be composed of empirical subjects (Simmel 1964) who are present in the flow of the experience under consideration (witnesses or an audience) or, alternatively, of a common meaning (even if differently shared) that allows stabilization and guarantees disputed legitimacy (Crapanzano 1992). In the following analyzed case, such meaning resides in the interconnection between notions of health, citizenship and ethnic identity. From this perspective, although different resources are considered to be violent depending on the context, the definition of violence that underlies this discussion retains certain formal characteristics: it is a material and symbolic instrument that is managed in particular relationships of power, whose configurations of triadic interaction are established to the extent that what is considered to be aggressive always craves some recognition of the validity of its action, even accepting its classification as violent. Therefore, an understanding of violence is not complete in considering the interaction with the attacked other, nor can it be based on content that is allegedly universalizable.

The two forms of violence in focus

Current public policy related to indigenous health in Brazil resulted from the 1988 Constitution, which redefined the national health system in the terms of the Unified Health System (Sistema Único de Saúde - SUS). This

policy made health a right of all Brazilians and an obligation of the State. It also transferred the care of indigenous health to the Minister of Health. Thus, in the process of creating the SUS, it was also possible to consider the design of a similar policy for indigenous health.

The Subsystem of Indigenous Healthcare, now part of the Unified Health System (SUS), is organized in a distinct way. It is structured into 34 Special Indigenous Health Districts. Considering the delimitation of ethnic criteria, these districts are expected to provide (1) health professionals, indigenous health and sanitation agents for basic healthcare and the conditions of basic sanitation; and (2) healthcare posts in towns, community health centers shared by groups of villages and Indigenous Nursing Homes – a type of shelter – for the referral of mid- and high-complexity cases to the SUS. This subsystem also includes local and district health councils for the definition and evaluation of district health planning, which are articulated with the National Health Council – the highest representative body of users in health policy.

This organization aims to guarantee the extension to indigenous peoples of the principles of universality, integrity and equality affirmed by the SUS, the participation of these peoples in health policy, or respect for indigenous healthcare practices and their articulation with biomedical services, with the goal of *"supporting the mitigation of the factors that make this population the most vulnerable to health problems of great magnitude and transcendence among Brazilians, recognizing the effectiveness of its medicine and the right of these people to their culture"* (FUNASA 2002:13).

In the configuration of values that constitute the institutional engineering of Brazilian indigenous health, the indigenous agents of health and sanitation assume prominence. In 2000, the year in which the subsystem was structured, indigenous agents constituted more than 50% of the care professionals (FUNASA 2004) who were asked to form links between the indigenous community and the health professionals, principally in the sense of promoting an articulation between traditional indigenous practices and biomedicine. This mediation was intended to ensure the recognition of specific ethnic and cultural groups in care (called *"differentiated care"*), thus allowing the subsystem to promote and restore the health of indigenous groups and contributing to the guarantee of the full exercise of citizenship. It is, therefore, an institutional function that, in its origin, presents a technical and political orientation. A look at the day-to-day practice of healthcare in the area of indigenous communities reveals the distancing between the *"language of imagination"* that characterizes the normative documents and the *"language of decision"* that this type of text seeks to appease (Geertz 1985).

In fieldwork undertaken over the course of 8 months in the Munduruku territories, many clinical situations that resulted in slights toward the patients and indigenous agents were observed (Dias da Silva 2010). In the first week, a nurse gave a talk for mothers on *"Sexually Transmitted Diseases, Cervical and Colon Cancer Prevention and Hygiene"*. Although an indigenous health agent had been called to translate the speech, the talk was started without him, despite the fact that the majority of the Munduruku women did not speak Portuguese. When he began to translate, it was only possible at the end of a long wait and without the necessary time to the main task of the indigenous agent: permitting communication between the health professionals and the Munduruku.

It soon became clear that the expressive power of the talk relied on a logic that disregarded the mediation of the indigenous agent. In the first place, a warning of the physical symptoms of illness (or the composition of a contamination index) was given after the explanation of images. The notion of an alert was considered to be fundamental for connecting to the audience via the establishment of the gravity of the situation through the visualization of the illness and the emphasis on the manifestation of the symptoms – composing an allegedly universal discursive practice. Then, the nurse constructed a new guide for the behavior of the people, responding to the alert via risk management through actions to change self-care aimed at the prevention of the illness under consideration.

In the specific case of the topic of hygiene, the connection between the alert and behavioral prescription was provided by the observation that the Amazon winter was beginning and that there were significant indices of illness due to contamination related to river water (diarrhea and worms). The nurse highlighted the recent installation of a water pump that allowed the production of a reservoir to supply the village. This pump helped to diminish these illness indices during the winter, when rain falls daily and all types of waste that are produced in the village polluted the river, especially the excrement of people and dogs. Regarding corporal practices related to hygiene, the nurse emphasized that it would be good to *"bathe everyday, in the morning, in the afternoon, and at night, to clean your house, to sweep, and to place trash in its place"*. These recommendation were very general comments marked by a sociological emptiness, and they did not make sense in the everyday experience of the Munduruku. Bathing three times a day and sweeping houses were consolidated habits among them, but the idea of defecating at the river bank did not have a connection to life in the village. However, this topic was part of the body of health education for coastal populations in general.

From this point, it appears that the patient (the subject of the action) was perceived in the context of the body of diseases that is projected based on the epidemiological profiles of indigenous peoples in general, and by assumption, the patients were considered to engage in causal conduct. In the event in question, the worms were always associated by nurses with a lack of hygiene and with mothering and childcare, ignoring the sanitary relevance of the absence of adequate local treated water and the burning of trash.

The richness of this ethnographic narrative rests in obtaining from the mode of articulation the two types of violence initially mentioned: symbolic and political violence. Finally, the ethnographic narrative reports an educational action in health without the mediation of indigenous agents, given in Portuguese to non-bilingual women (and without the necessary translation), in a universalist biomedical language of illness, symptoms and behaviors, and full of assumptions that are offensive to the Munduruku cultural way of life. In addition, this action is inconsistent with the health policy that has been in place since the Constitution of 1988 and that was reaffirmed in meetings between indigenous leadership and governmental management (Teixeira 2010). Characterizing interactions of this type of violence in the previously defined terms requires some final explication: who would be the third party, and what type of legitimacy is claimed by this action?

Between "care" and "tutelage"

This approach to (lack of) hygiene is the modern version of an exercise of power that characterized the hygienism of the 19th and 20th centuries because the biological universality of the routes of transmission of parasitic illnesses has led to a lack of consideration for (1) the cleaning practices that distinguish the self-care and the care of the environment of the people; and (2) their precarious material conditions of sanitation. On the one hand, a perverse process of displacing responsibility from governmental to indigenous entities is observed; on the other, the legitimacy desired by the proponents of this displacement is supported by the ideology of *"care"* that nursing typically holds. In addition, the ideology of *"tutelage"*, with the affirmation of the civil incapacity of indigenous peoples and their necessary protection by government guardians, although no longer legally valid, continues to influence the interactions between indigenous and non-indigenous peoples in general and in health policy.

Tutelage was historically a relationship of power that was based on the attribution of an intrinsic incapacity to indigenous identity that can only be overcome through fixation and full transformation into a worker and a Brazilian citizen (Lima 1995). In comparison, the contemporary actions of disease prevention, which are grounded in the self-care of individuals and which characterize the indigenous as dirty, require their adhesion to hygienic practices for inclusion into *"civilized"* society (Elias 2000) or as *"sanitary citizens"* (Paley 2002) deserving of the care of public policy. In both pathways, the relationships (of tutelage and care) imply a marked asymmetry and express themselves in acts of violence, the legitimate exercise of which claims to function in the best interest of the other, who is conceived as different and inferior – simultaneously constituting a rhetoric of benevolence and practices of subjection.

Final Considerations

In this context, the affirmation of the right to cultural difference, freed from the consideration of the historical and political processes that generated strong relationships of power between indigenous and non-indigenous peoples, has (contrary to the original intentions) reinforced these relationships. Thus, in the first place, the tendency arises for indigenous health agents to be transformed from policy mediators to cultural disseminators, but generally not teachers of actions recommended by health professionals. The intent to prevent illnesses with the participation of the *"community"* and not just to cure them, which is advocated by the World Health Organization, is transmuted into stigmatized corporal disciplines. The distance between the normative text and everyday practices, which distinguishes the relationship between the fixity of the document and the fluidity of action, constitutes the locus in which the techniques of governance are actualized.

There is not, therefore, a paradox between what is said in public policy and what is done in the everyday management of indigenous health. However, the very condition of exercising the political negotiation that requires the application of laws is mediated by different interests. The question is, under what conditions are these negotiations taking place? Thus, comprehending the day-to-day experience of the disempowerment of women and of the Munduruku indigenous agents, as well as the valorization of the indigenous leadership's authority in the political arena, requires their insertion into the context of the disjunction between the civil and political rights that characterize the experience of citizenship in Brazil (Caldeira, Holston 1999). This issue involves the absence of a guarantee of the exercise of the rights of citizenship that operate as a framework for everyday interactions (individual and social rights) and for the construction of a mode of democratic governance (political rights). The closer approach to indigenous citizenship in health negotiations on cultural rights and the demands for *"cultural sensitivity"* from health professionals make it difficult to reverse the conditions of profound inequality in which the negotiations between norm and practice are possible in everyday life of healthcare. Thus, the situation has weakened the very exercise of indigenous agency in health policy. The triad of these interactions of violence must be expanded to understand the complexity of actions undertaken in the name of protecting tutelage and healthcare that intersect in the actions of indigenous health but that are possible in the larger context of the construction of Brazilian democratic citizenship.

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Learning objectives

The most important key messages of this research are that:

1. The co-presence of ideology of tutelage and some conceptions of indigenous health care in the Brazilian democracy reinforce hierarchical power relationships and cultures of violence in personal and institutional levels.
2. Public policies for indigenous health in Brazil must consider broader configuration of power and values in seeking solutions for both kinds of violence.

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Evaluation of the frequency and the causes of the workplace violence against nurses and midwives, working in Iranshahr hospitals, South- East of Iran

Paper

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Focus: Research
Keywords: Workplace violence, Nurse, Midwife

Introduction

Work place violence, against health care personnel, is turned into a common and worldwide phenomenon. WHO (World Health Organization) have divided the Work place violence into the various types, like: physical violence, homicide, verbal abuse, sexual and racial harassments, invasion and psychological stress (1). Nurses that include major population of personnel in hospitals, and also are the most accessible personnel in hospitals, are located in the first line of the patients care. On the other hand, being in stress creating opportunities, such as accidents, death, delaying patients' visits by physicians, or transferring patients to other wards or hospital, may put nurses against more violence than other personnel, and may lead to more psychological and physical harms (2, 3). The consequences of violence may be serious for patients and organizations. For instance, violence can have negative effect on the quality of health care and also may lead to the nurse's absence from work, and workplace chaos (4). The results of several researches have indicated that, only 29% of the workplace violence are reported; because nurses have accepted them as their job specifications; and interpret violence as a time-consuming and ineffective action (5, 6). Though, according to the importance of this problem, workplace violence among nurses and midwives, less attention is paid to survey the causes relative to form the Workplace violence; and regarding the special geographical situation of South East of Iran, and multi-cultural background of its dwellers, researchers have decided to accomplish a research, to survey the frequency and the causes relative to the Workplace violence on nurses and midwives working in hospitals of Iranshahr- South East of Iran.

Materials and methods

This cross sectional research is accomplished in two educational hospitals in South East of Iran. A two parts questionnaire was utilized as an instrument to collect the data, including demographic data, and data about workplace violence. A questionnaire about *"workplace violence in healthcare centers"*, which was utilized in previous researches, was used in this research, too. Regarding Iranian cultural specifications, there was created some modifications in the questions relative to sexual harm and abuse (7).The definition of workplace violence inserted into the questionnaire to prevent various interpretations and perceptions about violence. To determine the content validity of the questionnaire, it was edited by eight faculty members of Iranshahr nursing and midwifery school. To determine the internal consistency of the questionnaire 25 nurses, who had the same characteristics as the research participants, had completed the questionnaire. The reliability of instrument was approved by alpha Cronbache's 86%. The first part of the questionnaire involved 11 questions relative to participant demographic information, and then16 questions relative to workplace violence experienced by the nurses and midwives during last 12 months. These questions included: the violence experience, the type of violence, the person who committed the violence and his/her sex, the reason of violence, the effect of violence on personnel, the reaction against violence and reporting of the violence. In this research, to obtain the data, convenience method was utilized. After getting conscious consent, the questionnaires were distributed between 145 nurses and midwives. 109 nurses and midwives had completed questionnaires, and then the collected data were analyzed.

Results

Demographic data is summarized in table 1.

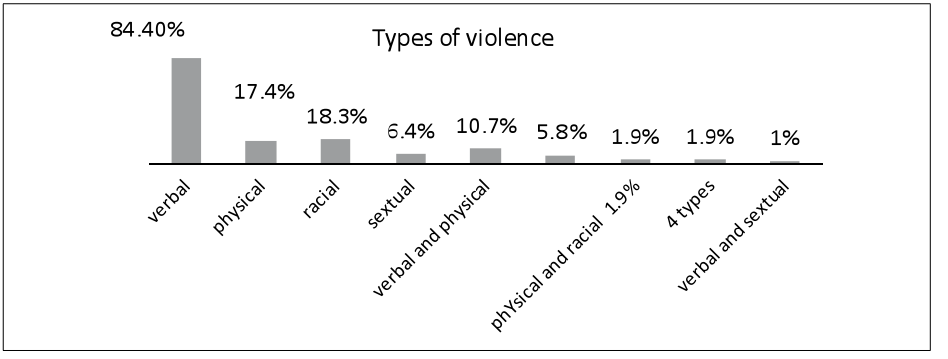
Table 1: Demographic data of participants of Iranshahr Hospitals

age	20-30yrs(68)	64.8%
	31-40yrs(33)	31.4%
	41-50yrs(3)	2.9%
	>50yrs(1)	1%
sex	Males=33	30.3%
	Females =76	69.7%

participants	Nurses =97	89%
	Midwives=12	11%
Degree	Bachelor:74	69.2%
	Other: 33	Other: 30.8%
Work Experience	1-5 yrs(77)	66.7%
	6-10yrs(19)	17.6%
	11-15yrs(10)	9.3%
	16-20yrs(2)	1.9%
	>20yrs(5)	4.6%
Shift Time	Circulating =59	55.1%
	Evening: 6	5.6%
	Morning : 32	29.9%
	Night:10	9.3%

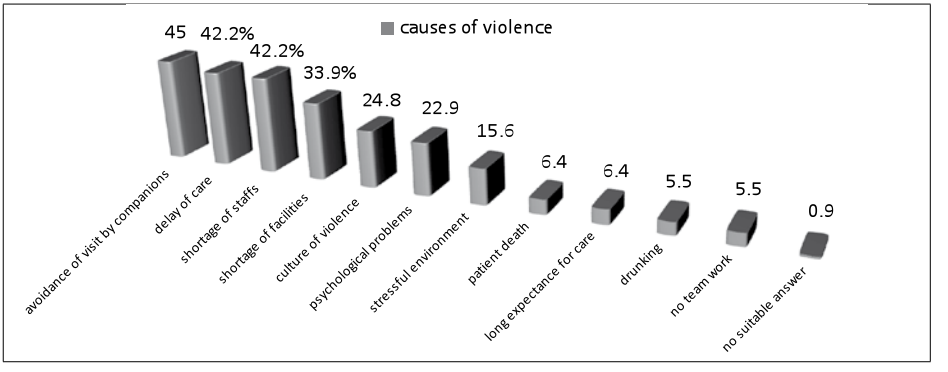
The findings of this research revealed that, 95.9% of these personnel had experienced a kind of violence during last 12 months. Verbal abuse was the most common type of workplace violence (chart 2).

Chart 2: Frequencies of all types of violence against nurses and midwives working in Iranshahr hospitals



77% of the personnel that reported verbal violence were females, and 33% were males. On the other hand, 30.3% of males and 9.2% of females experienced physical violence. The most physical violence have been reported in morning shift and circulating shift. 37.1% of the perpetrators of violence were the patients' companions, 5.7% were physicians, and 1.9% was patients. Also 53.8% cases of the violence had more than one perpetrator. 72.2% of the created violence in emergency wards was committed by physicians, patients, and their companions. Also, the most perpetrators of the violence in operating rooms were physicians. The most common causes of violence are summarized in chart 3.

Chart 3: The frequency of the causes of violence against nurses and midwives working in Iranshahr hospitals.



20.3% cases of violence had only one reason, in contrast to 79.7% with more than one reasons. The most common reactions against violence were lack of reaction against violence 46.8%, reporting violence to managers 32.1%, and utilizing problem solving methods 29.4%. The least reaction 0, 9%, was avenging in other situations, decision for changing job and utilizing anger replacing mechanism. The most common negative consequences that resulted

from workplace violence were anger 53.3%, job dissatisfaction 42.2%, and stress 36.7%. The most cases of workplace violence had occurred in emergency and trauma centers, operation rooms, and female surgical units. In 77.2% of cases, personnel had reported the violence to one of the managers, such as head nurses, supervisors, matrons, or the manager of hospitals. The other findings of this research indicated that, there was a significant relationship between workplace violence and the unit of workplace, statistically (p=0.00). Also, there was a significant relationship between workplace violence and gender (p=0.01). There was also a significant relationship between workplace violence and work shift (p=0.03). 31.1% of violence cases had been reported by personnel of morning work shift. There was a significant relationship between sexuality and physical violence (p=0.00). Also there was a significant relationship between verbal abuse and work experience (p=0.00). 56.5% of the participants who reported verbal abuse were nurses with 1-5 job Experience. But there weren't significant statistic relationships between racial and sexual harassment with gender of nurses and patients, the level of education, work experience, work shift.

Discussion

The findings of this research revealed that most of the nurses and midwives have experienced violence. The frequency of workplace violence varied between 1– 84.4%, which the results of other studies have approved it. In previous study the frequency of violence was reported to be between 0.4 – 89% (8, 9). According to the results of this research, verbal abuse was the most common type of workplace violence. Results of Kwak, Li and Law's research has approved this result (2).

The result of current research indicated that, the most cases of violence had happened in morning and circulating shifts, that is in compatible with the results of Shoghi, Sanjari and Shirazi researches, that most cases of workplace violence had occurred in morning shift(10). High frequency of workplace violence in morning shift may be related to the delay in patient's visit by physicians, delays in consultations, patient's transport to other health care centers, the shortage of personnel or facilities in that hospital, which could be the factor stimulus to start a violence. Also, the unawareness of patients or companions of the treatment process and necessary pursuits, low economical level and inability to pay the costs of treatment, as well as unappealing expectations of the patients' companions, were the most common causes of violence. The shortage and the number of the personnel in each work shift are effective on healthcare procedures and the type of interaction. Though, all these matters may act as a stimulus factors to cause violence.

The other findings of this research showed the consequences of workplace violence, such as anger, job dissatisfaction, and stress. Also, the results of Voyer, Verreault, and Azizah researches indicated the phenomena, such as anger and depression in personnel who had experienced violent cases that were in compatible with that of our research (11). In this research, 33% of the patients had reported more than one kind of the violence, which was in compatible with that of Kwak, Li and Law (3). Other findings of our research revealed that, the patients' companions, physicians, and patients committed the most violence. Even though, other persons, such as colleagues, head nurses, manager of hospital, matron, workers and watchmen of the hospital were also reported have committed the violence. Findings of the other researches also approved the results of this research (3, 10, 12). In our research, emergency center, operating room, and female's surgical wards were reported as the centers on which the most cases of violence had occurred, while in another research, findings showed that the most common wards on which violence had occurred were the emergency and trauma center and then male surgery wards (3). Stressful environment cause more violence. Findings of our research indicated that, more than two third of participants have reported the workplace violent to the hospital managers resources, while, according to the results of Kwak, Li, Law's research, only 1 – 3% of workplace violent had been reported to top managers (3). Perhaps, careful inspection of supervisors, existence of police in hospitals, or existence of watchmen in wards resulted to report of violence to the managers. Other results of our research indicated a kind of significant relationship between gender and workplace violence. Also, there was a significant relationship between gender and physical violence, but the relationship between verbal abuse and gender was not significant; because, almost 80% of women and men have reported verbal abuse; while 30% of men and 9% of women had reported physical violence. According the results of Shoghi, Sanjari, and Shirazi researches, there were significant relationship between physical violence and verbal abuse with gender (10). Perhaps, these results are because of the cultural differences of the people living in different parts of Iran. According to the results of the current research, there was no significant relationship between workplace violence and age; and people between 20 and 30 years of age, experienced the most violence. Similar results had been reported in the researches of Adib and Shen, Cheng, Tsai, Lee, and Guo (6, 13). But, the results of Ayrancy et al, and Hodgson et al, researches indicated opposite findings, so that, the nurses with more job experiences were exposed to more violence (12, 14). It can be interpreted that, nurses with less job experiences had the least experience on violence managing and forecasting the factors of violence; though it was logical that, this group of personnel experienced such cases of violence. Regarding the results of this research, violence against women was more common, and it was approved by the results of Ayrancy research (12). But the results of Gerberich and Adib indicated opposite results (8, 6). Perhaps, it is because, most of the participants in this research were women.

According to the results of this research, there was a significant relationship between verbal abuse and work experience, which was in compatible with that of Shoghi, Sanjari, and Shirazi (10). While in Hodgson research, personnel with more than 20 years of work experience had faced more workplace violence (14). Perhaps nurses with less work experience had the least experience in managing the violence, and directing the created opportunity, and foreseeing the violent creating factors, though it is logical for this group of personnel to experience more cases of violence. On the other hand, nurses with more work experience, have more patience and mood to bear and

encounter with violence, perhaps the justification of this matter depends upon cultural differences between countries.

Regarding that, our research was a kind of sectional research, and participants would recall some of their past mementoes, they may have caused some mistakes and lapse, so to control this problem, the last 12 months had been considered. The other limitation of this project was the various interpretations of the participants about violence, to solve this problem; the definition of workplace violence was inserted into questionnaire. Also, the secrecy of person's information and unfamiliarity of the questionnaire were also emphasized, though participants fill the questionnaire without any anxiety.

Conclusion

The findings of this research indicated that, a large number of nurses and midwives are exposed to workplace violence. Regarding the high number of verbal abuse and physical violence, managers of hospital should pay attention to this matter and accomplish more studies in relation to the methods of solving this problem. By determination of the possible causes of violence, managers of the hospitals should consider the special culture of the people, devise a program about the time of visit, removing of the shortages, providing hospital facilities, and employing personnel even conventionally, to solve the problem of violence, which can affect nurses' functions and the quality of patient care. Nurses should determine the causes of the violence, and try to remove them regarding their responsibilities and duties. On the other hand, the most committers of violence were patients' companion, patients, and physicians. Though, providing educational courses for nurses and physicians can be effective on the style of encountering with them. Regarding the high number of workplace violence in emergency and trauma centers, it is preferred to employ policemen and watchmen to surmount these problems.

Acknowledgment

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Learning objectives

1. Most common cause of workplace violence
2. Frequency and reaction to violence

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Chapter 8 - Physical/Injury impacts of aggression/violence

Victims injured by firearms assisted by the mobile emergency care service in Campo Grande-MS, Brazil

Poster

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Focus: Research

Abstract

Violence has grown in an overwhelming way in Brazil, raising the indicators of morbidity and mortality by external causes. Many times, the use of firearms makes fatal victims or victims who may remain disabled. This fact has increased the State's onus regarding hospital costs and also the number of life years that the young population loses, as it forms the majority of the victims. The present study aimed to survey the victims of injuries caused by firearms, assisted by Servio de Atendimento Mvel de Urgncia (SAMU -Mobile Emergency Care Service) in the municipality of Campo Grande, state of Mato Grosso do Sul (MS), in the period from April 2005 to April 2007 - the first two years of operation after the implementation of the service in the capital of the state. A descriptive, retrospective and longitudinal study was carried out, based on a documental analysis of the information system of the SAMU of Campo Grande. In the study, 233 events were described. The results showed 213 male victims aged between 20 and 24 years. The head and neck were the most injured parts of the body and the South region of the city was the one that concentrated most events. It follows that violence caused by firearms in Campo Grande, MS, affects the economically active population and comes from regions characterized by poverty and social inequality. This justifies the implementation of a free service like SAMU, which has had an important impact on the community's health.

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Resistance to care and effects on nurses in New South Wales, Australia

Paper

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Focus: Research

Abstract

Background and Context

Resistance to care (RTC) is a defensive patient response to nurses and associated behaviour ranges from minor irritation or non-compliance to aggression and violence resulting in injury to staff. Previous studies of RTC have been conducted in aged care settings on patient populations with dementia.

Purpose

The purpose of this study was to assess the prevalence of RTC in several clinical environments and the effects of RTC episodes on nurses.

Methodology

A cross sectional survey was conducted on a sample of 5,044 nurses from the NSW Nurses Association membership, representing five specialty areas of practice: emergency department, mental health, aged care and medical and surgical nursing. The response rate was 23.3%.

Findings

RTC episodes were reported to occur 2-4 times per week by 80% of participants, and more frequently in emergency, mental health and aged care settings. Nursing activities associated with RTC episodes were: assisting patients with activities of daily living, moving patients, procedures and assisting mental health patients. The RTC behaviours were similar to those reported for patient initiated violence however the resultant injuries were less severe and less frequent (18%). The professional and personal impact of RTC on nurses included: considering leaving nursing, fear and anxiety, powerlessness and helplessness, burnout, depression, low mood/ sadness, reduced morale.

Implications for practice and the organisation

RTC is a significant clinical challenge for nurses and recommended strategies to deal with this issue include adopting a calm manner; assessing the problem; setting realistic goals; rewarding achievement of goals; being creative and flexible, postponing nursing activities, distracting residents, and providing relaxation measures or substituting different forms of care. Health care employers should recognise the psychological outcomes associated with RTC episodes and injuries, and management support following these episodes is critical to minimise the effect on nurses, particularly through increased staff/unit support and debriefing.

Learning objectives

1. Resistance to care occurs in various clinical settings and resembles violent and aggressive behaviour however, it is a defensive response to staff and requires a different therapeutic response than recommended responses to aggression and violence.
2. The resultant injuries are less severe and occur less frequently, however the effects on nurses can be ameliorated by appropriate organisational support.

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Workplace violence in home care and employee exposure to needle stick injury

Paper

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Focus: Research

Abstract

Focus

The purpose of this paper is to examine the relationship between workplace violence, work stress and needle stick injury in a U.S. State wide sample of Registered Nurses (RNs) who work in home care. A secondary goal is to provide further evidence for the validity of the Home Visit Risk Scale (HVRS) to assess the risk of workplace violence in the home care work setting.

Background and context

The growing importance of the home as a setting for healthcare delivery in the US creates an important area of inquiry into the prevalence of occupational hazards to home visiting employees. Emerging evidence suggests that workplace violence may be an important source of occupational injury, workplace stress, lost workplace productivity, increased turnover and poor patient outcomes in the home care work setting.

Methodology

Data are from a mailed survey of RNs practicing in a U.S. Mid-Atlantic State that assessed work place conditions, workplace violence and blood and body fluid exposure via needle stick and splash exposure routes. Measures included the Home Visit Risk Scale (HVRS) which consisted of environment as well as client risks for violence, Kelloway and Lipscombs measures of verbal and physical violence, measures of needle stick injury and non sharps blood exposure, and the Job Content Questionnaire (JCQ) assessing work stress.

Findings/implications

In a sample of 794 home health care nurses: 96% female, 78% white and 17% African American, with a mean age of 48.9, 21% indicated they had experienced a needle stick injury. Physical assault was rare with 18 RNs (2.4%) reporting it, while 45.2% experienced verbal abuse from their clients in the past year. Each item of the Home Visit Risk Scale (HVRS) was associated with physical abuse, verbal abuse and blood exposure, furthermore as the number items increased so did the strength of the association. Home visit risk factors and violence were associated with blood exposure. High job demands, low job control and job strain were not independently associated with needle stick injury, but when violence was present with high job strain the odds of being exposed to blood increased.

Conclusions

Foreseeing home visits that are high risk for violence is important for home care worker safety. There is a substantial need to examine the home care work environment to develop engineering controls that can mitigate the risk of violence as well as improve the safety needles and disposal to reduce the risk of sharps injury. Worksite safety programs for health care professionals should also include training to handle hazards and difficult situations/clients that they might face as part of their home visit.

Learning objectives

1. Describe the elements of the home visit risk scale.
2. Describe the hypothetical mechanisms by which violence increases the risk of needle stick to home care workers.
3. Examine policy approaches to improved safety and reduction of the risk for injury from violence from home visiting work.

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Chapter 9 - Emotional/ psychological impacts of aggression/violence

Evaluation of the Code White Program to reduce workplace violence at St. Pauls hospital

Poster

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Focus: Education and Training

Abstract

The focus of the research study was to learn more about the relationship between Non-Violent Crisis Prevention Intervention (NCPI) training and response in order to strengthen the implementation of the program. Staff at St. Pauls Hospital, who had attended NCPI training and who had been involved in Code White incidents, were surveyed to identify their experiences of violence and aggression in the workplace, their receipt of training, the adequacy and relevance of the training in response to the incidents with which they were involved.

The data analyzed in this study was obtained in 2011 through a full survey of all staff in departments at St. Pauls Hospital where Code White incidents had occurred from January to December 2010. The research project used a post-test design. It was a quantitative, formative process assessment evaluation.

Quantitative data were analyzed by SPSS and thematic content analysis was done for the qualitative data. One-way and two-way ANOVA statistical procedures and Chi-square tests were used to analyze the quantitative data.

Overall, a relationship between the Non-Violent Crisis Prevention Intervention (NCPI) and preparedness level of staff to deal with crisis situations was established. As a point of interest, findings revealed that age of the participants did not have any impact on their preparedness level to handle violent incidents. The staff who received NCPI training demonstrated their ability to apply training techniques more often than those who didnt. Techniques addressed in training and used most often by staff include the timely provision of medication; limit setting; verbal de-escalation, and diversion.

Regarding the effects of violent incidents, most of the participants reported emotional responses, particularly, anxiety and frustration, fear, anger, upset, burn-out, compassion, tension and sadness. The most frequent supplementary responses centered around the lack of adequate support and preparedness following the incident. However, some of them found NCPI training techniques as useful coping strategies in handling such situations.

Respondents expressed their desire for ongoing training with refreshers with respect to Code White Training. It was suggested that better resourcing, facilitating better communication and collaboration among staff teams, offering joint trainings for staff teams (particularly, for nursing and security), increasing security presence and increasing medical intervention should be priorities for effective implementation of the Code White Program.

The results of the study support the continuation of the program and provides an understanding of the impact of the incidents on the staffs well-being. The findings also have implications for educators, trainers, and managers as they seek innovative solutions to strengthen the program implementation and determine the proper training for the particular needs of their staff. The approach implemented and evaluated at St. Paul's has lessons for any similar institution that seeks to maximize both patient care and employee safety.

Learning objectives

1. To raise awareness of the effects of violence and challenges that employees experienced in dealing with violent incidents.
2. To discuss the adequacy and relevancy of training techniques used by staff in response to the incidents.
3. To make suggestions for reducing workplace violence to maximize both patient care and employee safety.

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Psychological impacts of aggression in health care institutions: Theoretical perspectives

Paper

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Focus: Organisational
Keywords: Aggression; organization; self-esteem; unconditional positive regard, horizontal and vertical hostility

Introduction

The workplace, constituted by a group of individuals with different backgrounds and orientations, is inevitably subject to manifestations of aggression. However, organizational violence has a different impact when present in settings that provide care and hospitality services like health institutions. It is ironical that health facilities, custodians of safety assurance and health delivery, have suddenly become a theatre for aggressive behaviour. It is on record that the people responsible for the tension in hospitals are often the same people delivering health services. This development seriously threatens our collective sense of safety in hospitals. Becker (2005) argues that workplace aggression is a specific type of counterproductive work behaviour. According to Yoruba Adage; Ni bi ti erin meji ba ti nja koriko ibe lo ma for o ko - where two elephants lock their tusks, it is the grass around the site that suffers. This suggests that confrontation, which often exists between the gladiators (doctors and nurses), could have adverse effects on service delivery in hospitals.

Organizational aggression, ranging from petty forms of violence, which take place on a daily basis, to the highest level such as physical assaults may have deleterious consequences for the serene atmosphere that is the hallmark of a place where people receive medical attention. Aggressive behaviour among different categories of health workers deserves attention. This paper aims to highlight the issue with a view to sensitizing the populace on how to perceive and address the problem. The fundamental focus here is on the patterns and implications of aggression in hospitals and to trace its causes while offering solutions to the problem. The specific objectives of this paper are:

- to explore the nature of aggression in hospitals;
- to discuss its patterns, implications and causes;
- to encapsulate the phenomenon from the perspective of complex theories of Jung and Adler.

In addition, an attempt is made to present solutions based on the concept of unconditional positive regard as advocated by Carl Rogers.

The nature of aggression in the workplace

Aggression, in conventional terms, can be regarded as untoward behaviours against another person or group of individuals. It can also be considered as any behaviour that is carried out by an individual with a view to causing harm to another person or group of people (Anderson and Bushman, 2002). According to Anderson and Bushman (2002), the aggressor must believe that their behaviour is harmful to their victim(s), and that the target(s) will be motivated to avoid this behaviour. A defining feature of aggression is the intent or motivation to harm. In other words, if harm is inflicted on another without that specific intent, it is not considered aggression (Anderson and Bushman, 2002). In psychology, the term aggression refers to a range of behaviours that can result in both physical and psychological harm to oneself, others or objects in the environment. The expression of aggression can occur in a number of ways, including verbally, mentally and physically.

Aggression occurs in a variety of situations, but one important domain that has received attention lately is the workplace. Aggression in the workplace is a serious concern for organizations, whether it is called harassment, deviance, or bullying, workplace aggression can lead to a number of disturbing outcomes for an organization ranging in severity from low morale to injury and even death of personnel in the most extreme cases (Hershcovis et al ,2007).

Some researchers specify that workplace aggression only includes efforts to harm co-workers, former co-workers, current employers, or past employers (Neuman and Baron, 1998). Other scholars include any behaviours intended to harm another person that is carried out in a workplace (Peek-Asa, et al 2001). With regard to workplace aggression, two types of aggression are considered: interpersonal and organizational. Interpersonal implies aggression against individual co-workers while organizational involves some sort of aggression against the organization itself e.g. employers. For the purpose of this article, the focus is on interpersonal aggression in the workplace, i.e. aggressive behaviour among health workers in hospitals.

Kinds of workplace aggression
It may be difficult to distinguish workplace aggression due to its numerous forms and manifestations. This notwithstanding, researchers have developed workplace aggression classification schemes. Neuman and Baron (1998) offer three dimensions that encompass the range of workplace aggression: expressions of hostility, i.e.

behaviours that are primarily verbal or symbolic in nature; obstructionism, i.e. behaviours intended to hinder an employee from performing his/her job or the organization from accomplishing its objectives; and overt aggression, i.e. violent acts. In an attempt to further break down the wide range of aggressive behaviours in the workplace, Baron and Neuman (1996) apply three dichotomies: verbal–physical; direct–indirect; active–passive. Aggressive acts can incorporate any possible combination of these three dichotomies. For example, failing to deny false rumours about a co-worker would be classified as verbal–passive–indirect. Purposely avoiding the presence of a co-worker you know is searching for your assistance could be considered physical–passive–direct. Aggression can take a variety of forms, including: physical, verbal, mental and emotional (Berkowitz, 1993). It may also be classified as uncontrolled and predatory, based on emotional antecedents.

Purposes of aggression

Aggression, even though it carries negative connotations, can be useful at times. Aggression can serve a number of different purposes, for example asserting dominance, achieving a goal, expressing possession, as a response to fear, competing with others, etc. All these and many other reasons may stimulate individuals to express aggression. However, three of the reasons mentioned above are predominant among health workers. They are:

- Asserting dominance: an individual may put up some sort of aggressive posture to assert his /her authority in a perceived rebellion or uncooperative attitude originating from subordinates. For example, a doctor may employ aggression to assert his/her dominance on a staff nurse, while a nurse in turn may assert dominance on aggressive student nurses.
- A response to fear: One may use an aggressive posture as a defence mechanism to protect against an inner fear of inequality and inferiority complex.
- Competition: Aggression may be naturally expressed by people in conflict and those who perceive others as being in conflict with them.

Researchers (Dodge, 1991; Meloy, 1988; Raine et al., 2004) have suggested that individuals who engage in affective aggression, defined as aggression that is unplanned and uncontrolled; tend to have lower IQs than people who display predatory aggression. Predatory aggression is defined as aggression that is controlled, planned and goal-oriented (Dodge, 1991) - aggression intentionally carried out to achieve a certain end.

Patterns of aggression in hospitals

Aggression in hospitals as a phenomenon manifests itself in different ways. Stories are told about surgeons who throw instruments in the operating room or physicians who yell at the nurse for calling in the middle of the night. These actions exemplify overt behaviours displayed as physical or verbal aggression. However, there are also covert or subtle behaviours that can be just as detrimental to staff and patients. Nurses have often been associated with the phenomenon of *"eating their young,"* which occurs when new nurses are not supported by experienced nurses, but rather are thrown into a situation to learn via 'trial by fire.' All of these behaviours discourage teamwork which is essential for a healthy work environment. Meanwhile, the most prevalent types of aggressive behaviours in the hospital are bullying, hostility, criticism, in-fighting, bickering, undermining, to mention only a few. These manifestations are classified into different patterns. In this paper, two basic patterns of hospital aggression are given consideration. These include horizontal/lateral hostility and vertical hostility. An effort is made to analyze both patterns with the aid of illustrations and the findings of previous studies.

Horizontal/Lateral Hostility: It depicts certain forms of hostile behaviour among peers and colleagues. Roy (2007) simply puts it as an overt and covert non-physical hostility such as sabotage, scapegoating, finger-pointing, criticism etc. It can be described as hostility directed toward ones' equals or the perceived contenders in the ladder of career success. The peculiarity of horizontal hostility in hospitals underscores the contentious relationship among different categories of health workers. Research has shown that horizontal hostility exists in nursing (Woe lfle & McCaffrey, 2007; Thomas & Burk 2009). It is not uncommon to see a nurse being ridiculed or demeaned by a colleague.

Doctors and other health workers are not excluded from hostile behaviour. Rosenstein (2002) has also attributed destructive behaviour to physicians. Because of their status within the health care system, physicians are often the main focus of attention when it comes to disruptive behaviours. However, all groups of healthcare workers can be involved in these acts, including nurses. Rosenstein and O'Daniel (2008) studied hospital workers, including medical and nursing staff members, administrators, and other healthcare disciplines. Seventy-seven percent of the participants reported witnessing disruptive behaviours in physicians and 65% of the participants identified disruptive behaviours in nurses. Hader (2008) reported a study in which nurses were recognized as displaying disruptive behaviours more frequently than physicians (51.9% vs. 49%). Unlicensed assistive personnel have also been reported to display these behaviours (Stanley, Martin, Michel, Welton, & Nemeth, 2007). Rather than blaming one group of healthcare professionals, all healthcare workers are implicated and accountable.

Vertical Hostility: Unlike horizontal hostility, this is a form of hostility between individuals with unequal power. For instance, the kind of conflictual relationship between a registered nurse and interns; medical consultant and student doctors; medical doctor and staff nurses. Brown (2010) describes some 'scenarios' which portray the manifestation of hostile behaviour directed toward one's subordinates - a situation where a junior colleague is corrected openly on inevitable mistakes or when a staff nurse boasts about giving a hard time to the student nurse. Bartholomew (2006) agues that doctors can be rude with phrases like 'why are you calling me' or 'that

idea of yours is not important', while attending to patients with the nurse in attendance. She notes that this kind of comment undermines and disheartens. Furthermore, they shut down doctor-nurse communication.
This paper specifically focuses on horizontal hostility (aggressive behaviour from a nurse to another, a doctor to another) and vertical hostility (from a doctor to a staff nurse). Under horizontal violence, the most prevalent behaviours among nurses are criticism, sabotage, infighting, scapegoating and bickering, whereas behaviours such as bullying, sabotage, and criticism are common in vertical violence which underscores the relationships between nurses and doctors. Three of these behaviours were analyzed with real life experience illustrations.

Criticism: This describes a situation where nurses are fond of complaining about their colleagues or where doctors often complain about nurse behaviour. For instance, in the first case, a situation where a nurse keeps reporting and acknowledging every mistake made by his/her colleagues without lending a helping hand to correct the mistakes. Woelfle and McCaffrey (2007) found criticism to be a negative behaviour of staff nurses towards colleagues. Doctors often criticize nurses on duty for the inevitable human mistake. Doctors seem to derive satisfaction in reporting nurses' ineffectiveness to hospital management for appropriate sanctions. Otu (2011) argues that doctors sometimes feel that their status gives them the license to belittle nurses.

Bullying: Sometimes bullying takes place between employees, but it is most evident in supervisor – worker relationships, in which one person is perceived to wield greater power (Braverman, 1999). This assertion underscores the interface between nurses and doctors in the hospital. Doctors in a hospital setting, seem to wield greater power and sometimes treat nurses as their hand maidens. For example, a situation where a nurse attendant's contribution is made insignificant by a doctor's comment like 'that idea of yours is not important.' Adams and Crawford (1992) argue that bullying is a devious effort to make a colleague appear professionally incompetent.

Sabotage: This is a hostile behaviour that is capable of harming health workers and patients as well as the health organization as a whole. It is not uncommon to see a staff nurse sabotaging physicians' efforts by not following drug administration specifications. Many nurses may resort to this as retaliation for what she perceives as doctors' excesses. Nurses often transfer their aggression to patients when reacting to the doctors' behaviour. And this act may sabotage organizational efforts to provide good health service delivery. It is a hidden truth that the status hierarchy in hospitals favours doctors. Otu (2011) opines that doctors are on top, and some of them feel that their status gives them the license to belittle nurses. This action in turn can spark off retaliation in the form of sabotage by staff nurses.

Implications of aggression in health institutions

Significant studies (Martin,Stanley, Dulney & Pehrson, 2007; Demaroo & Roberts, 2003) have reported the extent of damage caused by horizontal/ vertical violence in hospitals and health centres. This paper explores the psychological impacts of aggressive behaviour among hospital health workers in terms of employees' self-esteem, work attitudes as well as its impact on patients receiving treatments and the healthcare institution itself.

(a) Employees self-esteem: Life situations, peer pressure and the environment in which a person is raised may serve as influential factors. Apart from societal factors, low self-esteem may develop from the accumulation of negative experiences individuals acquire at the workplace. Applying the conditioning principle, an employee who has repeatedly received blame could be made to learn helplessness and thereby develop feelings of incompetence. For instance, a nurse with a doctor or a young doctor dealing with an older nurse (matron) could be made to learn helplessness in such power struggles. Mathiesen and Einarsen (2007) found that those who were deemed victims of workplace bullying exhibited lower levels of self-esteem. Psychologically, low self esteem does not happen in a day: it feeds on an accumulation of various negative perceptions of oneself based on the interpretation of cues received from others. Many researchers find that if persons are satisfied with their work, their self-esteem increases. Others say one must possess high self-esteem in order to feel satisfied in his or her career choice and job field. High self –esteem, however, could be denied in an atmosphere that is characterized by animosity.

(b) Employees work attitude: generally, employees' working ability can be reduced by aggression, especially from superiors or employers. Though the law has no definite sanctions against certain boss attitudes such as arrogance, rudeness and stubbornness, other identified conditions, such as structural discrimination directed at the victim, are considered. Some examples from the hospital setting include doctors having temper outbursts and using loud profanity directed at any unfortunate nurse who happens to be near at hand or a nurse who surreptitiously withholds relevant information from young doctors to prove that experience is better than qualifications. Developments like these often result in poor work attitudes. Once employees' morale is weakened, attitudes towards work are affected.

(c) Patients: Baggs (2002) argues that the quality of the nurse-doctor relationships is directly linked to patients' mortality. This being the case, both physicians and nurses have an ethical obligation to have collegial relationships with each other. One can imagine the psychological torture that patients suffer when conflict takes over the team and the supposed synergies that are needed to improve their health. This scenario is probably confirmed by a comment made by Brown (2010) *"the problem is that nurses don't fight back against the people who put them in the corner."* It is possible that these overwhelmed and angry nurses take their frustration out on patients. The reality is clear to us that those doctors, while reacting to nurses' excesses, are prone to make

mistakes in dealing and prescribing necessary drugs to patients. Brown (2010) argues that one major consequence of poor communication between doctors and nurses in hospital is a reduction in patients' health care quality.

Many other studies have been carried out on the impact of aggression on patient safety and quality care; Rosenstein and O'Daniel (2008) reported that doctors and nurses in hospitals associate disruptive behaviour, such as the use of a rude tone of voice or threatening body language, with decreases in their communication. They contend that disruptive behaviour is linked to adverse events. For example, 71% felt disruptive behaviours were linked to medical errors, 27% felt disruptive behaviours were linked to patient mortality, 18% had witnessed at least one mistake as a result of disruptive behaviour. Communication decreases when individuals feel too intimidated to communicate with members of the healthcare team who are known instigators of these negative behaviours (Institute of Save Medication Practices, 2004). The Joint Commission (2011) reports that 60% of actual or potential harm to patients can be linked to insufficient communication in health care organizations. Farrell (2006) reports that two-thirds of nurses in an Australian study reported making errors when upset over incidents of aggression. Porath and Erez (2007) contend that ruminating about an experience of aggression by doctors and nurses takes cognitive resources away from other tasks and leads to increased errors and injuries. It is important to add that 1.5 million patients are harmed by medication errors each year (Institute of Medicine of the National Academies, 2006).

(d) Hospital health delivery: The whole essence of health care centres is to ensure quality care delivery services. However, the prevalent situation in our treatment centres today has made it almost impossible to have the serene and conducive atmosphere required for healing. This phenomenon is well captured in the policy statement of the Registered Nurses' Association of Ontario (2009): *"In addition to the impact on victims, significant organizational costs of violence in the workplace include increased costs for sick time and health care plans, increased absenteeism, lower productivity, stress-related illness, high turnover, decreased capacity to offer effective nursing care, increased costs for recruitment and retention, and diminished sense of professional competence with the potential to compromise patient/client health outcomes."*

Primary causes of aggression in hospitals

Workplace anger and hostility often manifest themselves in several ways and this has received a great deal of attention from scholars (Levesque, 1992; McShulskis, 1996; Neville, 2000). McShulskis (1996) argues that workplace violence and sexual harassment are probably the two best known examples of workplace anger and hostility. But anger and hostility can manifest themselves in other less dramatic ways that can nonetheless have a tremendously negative impact on an organization. Looking into the types of aggressive behaviour in hospitals is a big step towards stemming the menace. Studies have revealed several organizational factors such as injustice, poor communication, prejudice, favouritism and many other administrative factors as the cause of aggressive behaviour. This paper also reflects on personal and psychosocial factors which give rise to aggressive behaviour in hospital settings. The following are a few of the factors that serve as primary catalysts:

(a) Individual differences: The workplace provides an environment where people from different backgrounds meet on a daily basis, including weekends as the nature of hospital work demands. Health workers, regardless of their professional competence, are employed as a unit, a work team that caters to the needs of patients. Each employee contributes to the team's goals with his or her professional background as well as idiographic disposition. Levesque contends that *"one of the more obvious conditions in the workplace is that people, in their roles as employees, are distinguished by their vast differences"* (Hillstorm & Hillstorm 2002, p. 1180). He asserts that they come in all forms, with divergent experiences and backgrounds, and a remarkably unique psychological makeup. Some are quite stable in their values, lifestyles, reasoning, action, and direction. Some may be self-serving, deceptive, rebellious, or in many other ways problematic. These individualistic tendencies can be a source of conflict.

(b) Envy tendency: Human beings seem to be naturally envious. Williams (2008) argues that envy is usually aggravated by low self-esteem or lack of assertiveness, e.g. when a colleague has something we want, instead of feeling pleased for him or understanding why they are in a better position, we feel inferior and start to resent their success. Envy is wanting what another person has, resenting it or thinking we should have been the one to have it. Envy when it is motivated by social comparison leads to competition, which in turn metamorphoses into rivalry behaviour. The relationship between nurses and doctors could be better described using the template of social comparison. Structurally, hospital work settings seem to provide more combustible ingredients for social comparison among health workers. Doctors, both male and female, in hospital settings are often revered as hard driving, charismatic people who possess special education (duration of training), while nurses and other health workers are regarded as supporting staff. This development undoubtedly fuels the flames of envy among employees.

(c) Rivalry tendency: Sibling rivalries are good practice for the conflicts we later see in competitive arenas like sports, politics and the workplace. Rivalries surround us as competition is prevalent throughout the animal kingdom. Human rivalries are more complicated; humans, in addition to food and love, fight for time, attention, recognition, and many other things. Predisposing factors in rivalry behaviour may not be farfetched. Like envy, hospital organizational structure could be responsible for rivalry among health workers. Again, other factors such as age, perceived image, low self-esteem, inadequate education may aggravate hostility behaviour used as defence mechanisms. For instance, the age factor alone is a big issue in hospital relationships. It is not uncommon to see the older nurse forced to adjust to the reality of taking orders from young doctors who might be the age

of his or her first child. In fact, many doctors upon graduation tend to claim more power in the relationship between nurse and physician. Thus rivalry behaviour can be difficult to control, especially for those at the receiving end like nurses and other category of health workers.

Envy and rivalry behaviour between doctors and nurses in hospitals: Theoretical explanations

The complex theory of Carl Jung(1960) and Alfred Adler (1964) was adopted to explain the antecedent of rivalry tendency, which culminates into hostility behaviour among some health professionals. Carl Jung adopted the term complex to describe his body of theories, i.e. complex psychology. Jung described a complex as a 'node' in the unconscious; it may be imagined as a knot of unconscious feelings and beliefs, detectable indirectly through behaviour that is hard to account for or puzzling. Carl Jung distinguished between two types of unconscious mind; the personal unconscious and collective unconscious (Dewey, 1958). The personal unconscious was the accumulation of experiences from a person's lifetime that could not be consciously recalled (Dewey, 1958). The collective unconscious, on the other hand, was a sort of universal inheritance of human beings, a *"species memory"* passed on to each of us, similar to the motor programmes and instincts of other animals (Dewey, 1958). Early in Jung's career, he developed the concept of the *"complex"*, which he described in his personality theory as building blocks of the psyche and the source of all human emotions (Daniels, 2003). Jung believed that the personal unconscious was dominated by complexes (Dewey, 1958). Complexes are thought to operate *"autonomously and interfere with the intentions of the will, disturbing the memory and conscious performance"* (Corsini, 1994, p. 279). In a similar vein, Adler (1964) relates complex to an adult's experience of being able to reach an unconscious, fictional final goal of subjective security and success to compensate for feelings of inferiority.

Jung often used the term *"complex"* to describe a usually unconscious, repressed, yet highly influential symbolic material that is incompatible with consciousness (Daniels, 2003). Jung spoke of one specific type of complex, an autonomous feeling-toned complex, when he said *"what then, scientifically speaking, is a 'feeling-toned complex'? It is the image of a certain psychic situation which is strongly accentuated emotionally and is, moreover, incompatible with the habitual attitude of consciousness"*(Cope, 2006, p. 116). This image has a powerful inner coherence, it has its own wholeness and, in addition, a relatively high degree of autonomy, so that it is subject to the control of the conscious mind to only a limited extent, and therefore behaves like an animated foreign body in the sphere of consciousness. Jung included the ego in a broadly comprehensive theory of complexes, often referring to it as the ego-complex. Daniels (2003) argues that some complexes usurp power from the ego and can cause constant psychological disturbances and symptoms of neurosis. Jung described the power complexes exert when he said *"what is not so well known, but far more important theoretically, is that complexes can have us. The existence of complexes throws serious doubt on the naive assumption of the unity of consciousness, which is equated with 'psyche,' and on the supremacy of the will. Every constellation of a complex postulates a disturbed state of consciousness. The unity of consciousness is disrupted and the intentions of the will are impeded or made impossible."*

Moreover, Jung identified the development of the differentiating functions as essentially the development of useful complexes. In his book titled Psychological Types, Jung describes in detail the effects of tensions between the complexes associated with the dominant and inferior differentiating functions in highly and even extremely one-sided types. Adler was able to advance the use of language to further simplify these dual differentiation functions of complexes. He used words such as inferiority and superiority feelings, compensation and overcompensation to describe inner states of human beings. In his book The Neurotic Character (1912), he held that the individual converts feelings of inferiority to superiority. Adler -as opposed to Sigmund Fred- believed that striving for superiority is the most basic human drive (not sexuality). Everyone is always striving to be better than others. It is not that we are jealous of others, nor that we are envious or much less covetous - it is that we are wired to feel superior. He was of the opinion that when we fall short in our efforts, we tend 'to compensate' that feeling of inadequacy with neurotic and often aberrant behaviour. For some people those inabilities and inadequacies become threats to their well being, causing them to lie, belittle, demean, or even slander others. This then is a manifestation of an 'inferiority complex.'

Linking implication of the theory to envy/rivalry behaviour with aggression between nurses and doctors in hospitals

The present study attempts to explain the cause of aggressive behaviour in hospital from the perspective of the complex theory as expressed by Jung and Adler. Complex theory expressed by Jung indicates that envy and rivalry tendencies which lead to aggression represent an overt expression from the knot of unconscious feelings and beliefs in every living being. Psychologically speaking, aggression can be considered an expression feeling tone that hijacking our consciousness based on conclusions we make from an unconscious state of mind. Jung believed that a complex basically blocks of the Psyche and the source of human emotion. Thus, aggression orchestrated by envy and rivalry tendencies has its source in the complex and all humans are naturally susceptible. Complexes are thought to operate *"autonomously and interfere with the intentions of the will, disturbing the memory and conscious performance"*. This assertion accounts for the reason why we as human beings often get carried away in spite of our intention to use aggression to achieve certain ends. Given the explanation above, one could conclude that aggression orchestrated by the envy and rivalry tendency has an emotional tone, which is being governed by the complex that hijacks our consciousness. If Jung has succeeded in providing an implicit antecedent of human aggression, Adler on the other hand, preferred to settle for an explicit explanation of human aggression.

The utility of Adler's theories is applicable for instance in the work place. No work environment is free of individuals who are hard to get along with, difficult, or unmanageable. Those whom we perceive as hostile or obnoxious are really just like anyone else who is striving to assert his or her superiority. Therefore, by putting ourselves in their shoes, we can understand their behaviour better and perhaps get along with them better. Given the work environment that condones competition, which gives room to envy and rivalry tendency among workers, one can understand this problem better in terms of the inferiority/superiority concept. Frustrated and overcome by feelings of low self-esteem, many workers over-react in an attempt to compensate for their intense inferiority complex. The basic understanding one can develop is that aggression has its antecedent from the human tendency to compensate for an intense inferiority complex.

Adler (1964) argues everyone is always striving to be better than others, that we are wired to feel superior. He was of the opinion that when we fall short in our efforts, we tend 'to compensate' that feeling of inadequacy with neurotic and often aberrant behaviour. The direct application of both theories to aggression in hospitals could be summarized as follows: the human manifestation of aggression according to Jung means unconscious and emotional-toned materials (envy and rivalry feelings) hijacking our consciousness. On the other hand, according to Adler, people's aggression is neurotic and aberrant behaviour which results from superiority or inferiority complexes. Human beings have the need to establish superiority over others, which promotes competition, envy and rivalry tendencies and overt expressions of aggression. Thus, doctors and nurses being human are susceptible; this implies that doctors' behaviour towards nurses and other health workers, which is regarded as hostile could be attributed to his or her basic need for superiority and mastery of the external world. At another level, it could be considered efforts to compensate for his or her feelings of inferiority. This is also applicable for nurses and other health workers.

The way forward

Aggression among doctors and nurses in hospitals poses a threat to general health service delivery. It is, therefore, expedient to tackle this hydra-headed monster. Many scholastic works have linked the source of aggression to different factors. In fact, many of the studies have specifically focused on the apparent rivalry between nurses and doctors and its attendant consequences. Thus, a lot of awareness has been raised in this regard. However, the present paper considers the need to find a lasting solution given the multiple effects on general health service delivery. This paper presents a solution based on the wider application of the principle of unconditional positive regard since the source of aggressive behaviour can be traced to human complex principles.

Unconditional positive regard, a term coined by the humanist Carl Rogers (1961), is basic acceptance and support of a person regardless of what the person says or does. Rogers believes that unconditional positive regard is essential to healthy development. People who have not experienced it may come to see themselves in the negative ways that others have made them feel. By providing unconditional positive regard, humanistic therapists seek to help their clients accept and take responsibility for themselves. Humanistic psychologists believe that by showing the client unconditional positive regard and acceptance, the therapist is providing the best possible conditions for personal growth to the client. Unconditional positive regard can be facilitated by keeping in mind that all people have the internal resources required for personal growth. Rogers' theory encouraged other psychiatrists to suspend judgment, and to listen to a person with an attitude that the client has within himself the ability to change, without actually changing who he is.

The concept of unconditional positive regard has wider implications beyond the therapeutic arena and simpler meaning outside of the therapist's goal to elicit change. It is the simple act of one individual accepting all traits and behaviours in another individual, as long as is it does not entail causing significant harm to oneself. The key word here is *"significant"*. If one states that *"This person's behaviour annoys me, and thus is causing me 'significant' harm"*, then unconditional positive regard is made subject to so many objections that it cannot exist. Thus, finding a person's behaviour/beliefs reprehensible when they pose no threat of harm to oneself or others, is incompatible with unconditional positive regard. To treat a flaw in an individual's otherwise harmless behaviour or beliefs as the reason to reject the individual's worth and merit to interact is a violation of the unconditional precept.

As stated earlier, human complex is considered as the basis for expressed rivalry tendencies, which culminate into aggressive behaviour. For instance, Jung would see rivalry tendency and aggression as a behaviour originated from our unconscious realm, which is puzzling and difficult to account for, whereas Adler would see them as common human expressions depicting our natural aspiration to attain superiority and mastering our external world or as efforts to cover up for our inadequacy and inability to master our external environment. Adler would simply describe this phenomenon as a lifestyle, which results from our interaction within our social environment. Given these propositions, this paper, using the unconditional positive regard precept, postulates that individuals should consider aggression or hostility behaviour from another person as an expression of his or her complexes. Bearing in mind that this expression is rooted in his or her unconsciousness and connotes efforts which aim at helping that person to master the external world.

We must realize that this behaviour may come from us directed to another person. It is expected that others should accept our behaviour in the same way. Thus, doctors should position themselves to accept a staff nurse's excesses as behaviour from his or her unconscious and its expression an effort to accomplish mastery of the external world. Similarly, nurses should view doctors' aggression in the same light.

The paper also postulates that individuals should learn to suspend judgement and accept all traits and behaviours in other individuals. That is, nurses and doctors should stop judging one another but learn to accept all traits and behaviours from each other. Our ability to attain this level of maturity can help us treat our fellow humans or workers' behaviour as the one that cannot cause any significant harm to us. Some useful components of unconditional positive regard are highlighted below.

- Respect: respecting a person in their dignity and brokenness as a person.
- Non-judgmental: being neither judgmental against nor for.
- Acceptance: accepting the person in all their fullness, missing nothing out, including how they treat the relationship with you.
- Valuing: embracing the person you encounter, and valuing them as a unique and valuable person.
- Prizing: celebrating achievements and what is of value in the person's eyes.
- Caring: being concerned for the person, and wanting the best for them.
- Nurturing: wanting to help the person to grow in whatever ways are open for their growth as a person (nurturing the actualizing tendency).
- Compassion: feeling compassion for how hard life can be for a person struggling to cope, or to find what is important to them, in a world that they may experience as hostile.
- Warmth: experiencing warmth inside for the person in this relationship.
- Love: experiencing the full richness of a non-possessive love for the person in this relationship.

Our devotion to the above humanistic version of the ten commandments could be used to work out an amicable relationship between workers and most especially used to evolve and strengthen cordial relationships between nurses and doctors. This will go a long way to promote team spirit, which hospitals and health centres require for guaranteed and quality health service delivery.

Conclusion

Aggression and any form of hostility are not specific to hospitals or health centres. Rather, it is manifested in all spheres of human environments. What however remains incomprehensible is its manifestation in health care institutions and the custodians of health care delivery (nurses, doctors and other health workers). This paper highlights the concept and patterns of aggressive behaviours in hospitals. Attention is also given to its implications for workers, patients and hospitals. The cause of aggression is linked to human beings' envy and rivalry tendencies, which has a complex undertone. Based on the complex theory postulated by Jung and its extended version by Adler, the paper argues that human complex forms a major antecedent for feelings of rivalry and its attendant aggressive behaviour. Consequently, the paper advocates that 'unconditional positive regard' must be embraced by all categories of health workers, especially doctors and nurses to reduce its occurrence. Since aggression is associated with human complexes, it is recommended that personality tests be made compulsory at the point of entry for all categories of worker in health care institutions.

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Learning Objectives

1. Participants will learn patterns and implications of aggressive behaviour in hospital.
2. Participants will be able to link envy and rivalry tendencies with aggression.

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Mental health nurses' experiences of patient assaults

Poster

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Focus: Research

Abstract

With the advancements in technology, there has been a significant reduction in the classical risk factors at the workplace like biological, chemical and physical harms. But with the turn of the era, much attention has been focused on psychosocial stressors at work which are thought to affect employees' occupational functioning and health. Violence against healthcare professionals is a major problem in today's health sector across the globe. Amongst all healthcare professionals, nurses are the most likely to be assaulted. Moreover, violence towards mental health nurses has been both a reality and concern due to increasingly violent patient population and the devastating effects of violence on the victim. Mental health nurses frequently encounter situations that are tense and unpredictable, and these factors are known to increase stress levels.

The study aims to explore and describe mental health nurses' experiences of patient assaults. Thirteen Registered Nurses and one Enrolled Nurse working in different nursing positions within the Southern District Health Board (Otago region) - Mental Health Services were interviewed using a semi structured interview format. The data gathered from these interviews was interpreted using thematic analysis and coded into 20 sub-themes. The sub-themes were organised via sub-thematic clusters into related groups. The sub-themes were related to the sequence and impact of assaults on the participants. Through an ongoing interpretative process, three over-arching themes emerged. The themes were analysed further to allow conceptual meanings to be interpreted relating to the experiences of patient assaults.

The major findings of the study related to the nature and impact of assaults and supportive strategies associated with violence perpetrated by patients against mental health nurses. Perpetrator risk factors for patients include mental health disorders, alcohol and drug use, inability to deal with situational crises and possession of weapons. The injuries sustained by the nurses within the context of the study include lacerations, head injuries, dislocations and bruises. Psychological harm has also occurred including quite severe mental health problems such as Post Traumatic Stress Disorder. Some of the injuries sustained have required weeks of recovery. In other cases, nurses have chosen to change areas of practice because of their fears and / or concerns. Protective strategies for combating negative consequences of workplace violence include practicing self-defence, self and social support, encouragement to report violent activity or any perceived threats of violence to authority and police and a supportive and consultative workplace culture with access to counselling services and assistance in all aspects including finances.

Nurses along with other healthcare professionals as victims of workplace violence may suffer physical, psychological and emotional harm. Although physical injuries heal relatively quickly, emotional and psychological wounds linger for longer and can interfere with personal and professional lifestyles for months or years after the incident. Health care employers need to provide more better support services to health care professionals who are assaulted and the legal system needs to acknowledge that assaults against nurses is violation of human rights and violence is not to be tolerated as part of working in mental healthcare services.

The study indicates that workplace violence is not merely an occupational health issue, but may have significant implications on the lives of nurses and other healthcare professionals. Physical and verbal attacks on nurses are more common than anyone realises and even though the perpetrator of violence might be able to point to mitigating circumstances for their actions, this does not make it justifiable or acceptable. Supportive and consultative workplace culture is crucial to reduce the negative impact of workplace violence.

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When helping hurts: Violence, trauma, and healing in the health sector

Workshop

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Focus: Practice
Keywords: violence; trauma; compassion fatigue; energy healing; resilience.

Introduction:

During this 90-minute presentation, three nursing teachers will review, through use of a learning activity, the effects of compassion fatigue on healthcare professionals. Participants in this workshop will also gain an understanding of the current definitions and terminology used in relation to violence in the health sector. Participants will gain experiential knowledge on how to cope with, and move forward in, a healthcare system where violence, harassment and trauma are present. The following scenarios will become part of the discussion and dialogue of the presentation.

Healthcare Vignettes

1. **Sexual harassment:**
   A new nurse, Sue, is working on a specialty unit. One of the specialists has noticed Sue and is happy when she is caring for his patients; other nursing staff notice his interest. After avoiding him for several shifts, the physician corners Sue in the supply room. He expresses his desire for her and asks her out. Sue now feels uncomfortable on the unit and is thinking of transferring to another ward.

2. **Trauma of a community:**
   A single vehicle carrying 3 teens crashes resulting in the on-scene deaths of two teens and the critical injury of the driver. Through social media, word of the accident spreads quickly throughout the small community. Emergency service workers (police investigators, fire crews, paramedics) are sworn at and spit upon by a crowd that forms at the accident scene wanting information about the deceased and the driver. Similarly, at the hospital, while trying to treat the life-threatening injuries to the driver, emergency department staff are faced with verbal abuse (swearing, threats) and physical abuse (pushing, shoving) from friends/families desperate for information about the victims.

3. **Bullying:**
   A nurse is working night shift in the emergency of a small rural hospital. She has just helped to set up a suture tray for a surgeon who is about to repair the scalp laceration of a patient who has been recently admitted. As the nurse turns to retrieve something from the cupboard, she hears the surgeon begin a tirade about the dullness of the suture scissors. The next thing she knows the suture scissors are bouncing off the wall beside her and landing on the floor. The surgeon says, *"I don't know how many times I have to tell you these scissors are dull! Get me a new pair!"*

In Western culture, people have become impervious to violence in society. Images on the news, television and in the media are full of horrific images of murder, devastation and loss. Further, individuals who work in the health care sector, such as nurses, students and other workers, are more at risk as they are exposed to violence, both verbal and physical (Jackson, Clare & Mannix, 2002), sexual harassment (Bronner, Peretz, & Ehrenfeld, 2003), and traumatization in their work world (Bronner, Peretz, Ehrenfeld, 2003). In these situations, the nurse or health care worker is at risk for being traumatized by the events (Collins, 2003). The outcome of individual personal experiences caused by workplace violence has been termed compassion fatigue (Joinson, 1992), vicarious traumatization (McMann & Perlman, 1990), secondary trauma stress (Figley, 1995; Munroe, Shay, Fisher, Makary, Rapperport, Zimering 1995), burn out (Pines, 1993) to name a few. These words help to define and refine the trauma of workplace violence. Naming this human experience also assists nurses to develop actions to help the individual, institution, or culture, and to provide recommendations and strategies for improvement (Rippon, 2000). This presentation will help individuals who work in the health care system to recognize violence in the workplace, and will assist the individual and the organization to foster healing.

Abuse of the health care professional occurs when they are verbally or physically attacked by patients and family (Jackson, Clare & Mannix, 2002), sexually harassed (Bronner, Peretz, & Ehrenfeld, 2003), bullied by other nurses, managers and physicians (Jackson, Clare & Mannix, 2002), or bear witness to the tragedies of patients/families (Boyle, 2011; Collins & Long, 2003).

Stress and the effects of stress are at epidemic proportions in our society (Abendroth, 2011; Mate, 2003). Stress affects work, relationships, families and quality of life (Abendroth, 2011; Leka & Jain, 2010; Mate, 2003).

Stress leads to anxiety, depression, panic attacks, cancer, diabetes, and chronic diseases (Mate, 2003; Leka & Jain, 2010).

Registered nurses within Canada and in British Columbia have the highest amount of sick time usage in relation to any other occupation (Shields & Wilkins, 2006; Informetica Ltd., 2011). Much of the sick time is long term and is paid out in disability dollars at great cost to the Canadian health care system (Almost, et al., 2002; Shields & Wilkins, 2006; Canadian Institute for Health Information, 2007;Informetica Ltd., 2011). For example in 2010, 8.1% of public-sector health care nurses were absent each week; out of 237,000 Canadian nurses, this equates to 19,200 nurses (Informetica Ltd., 2011). In 2010, the cost to the Canadian health care system for nurses' absenteeism due to illness or disability was $758.1 million (Informetica Ltd., 2011). The literature indicates a clear link between work-related stress and sick time (Almost, et al., 2002; Shields & Wilkins, 2006; Leka & Jain, 2010). Almost et al. (2002) for the Canadian Health Services Research Foundation: *"… identified musculoskeletal conditions/injuries (90%) and stress/burnout (85%) as the major work-related health problems of nurses. Other frequently mentioned physical health problems included stress-related illness (such as gastro-intestinal problems) and exposure to risk factors like infection and chemical hazards…[A]nxiety, low morale, and depression were the most common mental health concerns reported."* (p 14)

There are a number of occupational stress outcomes for healthcare providers, including burnout, compassion fatigue, and secondary traumatization.

Compassion fatigue has been defined as: natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other – *"the stress resulting from helping or wanting to help a traumatized or suffering person"* (Figley, 1995, p.7). Nurses are at risk for compassion fatigue as they are exposed to traumatic events or perceived threats on a daily basis (Abendroth, 2011; Boyle, 2011; Figley, 1995; Joinson, 1992). Some of these events include violence in the workplace, working with victims of trauma from accidents, trauma from participating in surgeries, working with patients suffering from overwhelming medical complications, working with families experiencing overwhelming stress in relation to their loved ones, ethical dilemmas, traumatic births, traumatic deaths, natural disasters, and unprecedented uncontrollable change in the workplace. Levine (1997) states, *"To witness human carnage of any kind, especially on a regular basis, exacts its own toll and is often as traumatic as experiencing the event firsthand"* (p 11).

Compassion fatigue is different from burnout, secondary or vicarious trauma, and counter-transference (Austin et al, 2009; Boyle, 2011; Joinson, 1992) and is defined variously as *"a state of psychic exhaustion"* (Boyle, 2011, 7) and loss of the ability to nurture (Joinson, 1992). Compassion is fundamental to nursing practice and is a *"requisite [nursing] competency"* (Boyle, 2011) *"to foster connectedness and offer nurturance to those requiring nursing care"* (Dunn, 2009, p. 222). Figley (1995) calls compassion fatigue the *"cost of caring"* (p. 1). Nurses' work puts them at risk for compassion fatigue simply because of the values of caring and compassion inherent in the profession. Compassion fatigue occurs in response to the stressors that a caregiver finds in their work. Boyle (2011) notes five risk factors for compassion fatigue: affective states; cognitive expectations and individual capacities to process information; ego-defensive processes; stress effects on the helper's self-capacities, ideological beliefs, and systems of meaning; and coping abilities and techniques of stress management. The results of compassion fatigue manifest physically, emotionally, socially, and spiritually. These manifestations appear as fatigue, increased somatic complaints, depression, and feelings of anger or rage leading to apathy and detachment from work and life, flashbacks, feelings of alienation, loss of interest in hobbies/activities (Bush, 2009; Boyle, 2011, Figley, 1995). In addition, compassion fatigue is seen as a disconnection from friends/family, sense of aloneness and spiritual isolation, and inability to find meaning in life; these reactions in turn affect work life through absenteeism, lateness, decreased performance/productivity, avoidance of patient situations, etc. (Boyle, 2011; Bush, 2009; Figley, 1995).

Given that the risk of compassion fatigue may be inherent to healthcare and to nursing in particular, what are some solutions that can retain healthcare providers in the field and mitigate the effects of occupational stress such as compassion fatigue?

Quantum physics, or chaos theory, proposes that any living system, be it individual or organizational, becomes brittle, inflexible, and unable to take in new ideas or adapt when it lives in fear and with ongoing, unrelenting stress. If a living system becomes brittle, inflexible, unable to take in any new ideas or adapt, it is called entropy. When a system becomes entropic it is close to death. In order for a living system to survive, it needs to become autopoetic. It needs to be able to adapt, to become resilient. The only way a living system is able to adapt or become resilient is by maintaining the complexity of its system, by renewing, regenerating and adapting within the organization of the system (Capra, 1996; Kelly & Allison, 1999). In this way, the system survives.

The underlying cause of violence in the workplace is unrelenting fear (Kelly & Allison, 1999). When an organism is fearful for its survival it will strike back before running away. When an organism is unable to run, the ongoing fear becomes violence (Scaer, 2005). Physical and psychological illness even to the point of death result when fear becomes inherent in the structure of the organism (Kelly & Allison, 1999; Levine, 1997; Scaer, 2005). As a result of dysfunctional behavior patterns, fear creates a downward spiral within organizations; horizontal violence is a by-product of this dysfunctional behaviour pattern.

The solution is to cultivate nurturing places of work or relationships. An organization that promotes resiliency within itself and within the individual is pivotal in this proposal. The first step is becoming conscious of the role

that fear plays within each person and within the organization. It is imperative to develop and nurture ways of grounding, centering, and aligning within self and the organization in order to come from a place of an open heart that holds unconditional love and positive regard (McCraty, 2001; McCraty & Childre, 2010).

This interactive workshop will explore workplace violence, define and differentiate compassion fatigue from other forms of occupational stress and provide opportunities to participate in and practice nurturing, positive ways of being. These ways of being, in turn, have utility to anyone in any organization that is experiencing violence and/or trauma.

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Learning objectives

1. Raise consciousness about the insidious, as well as the overt, impact of violence in the workplace.
2. Using a holistic perspective, develop competence in specific strategies for managing the stress and compassion fatigue that results from violence in the health sector.

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Home care nurses' appraisals and coping strategies in a critical incident

Paper

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Focus: Research
Keywords: home care nurses, critical incidents

Background

In the early 1990s, researchers began to study critical incidents in nursing. Burns and Harm (1993) studied what traumatic situations emergency nurses perceived as critical incidents. In 1994, Appleton expanded on this work and included general medical/surgical nurses in order to explore what events they appraised as critical events. Nearly ten years later, O'Connor and Jeavons (2003) investigated Australian nurses' perceptions of critical incidents. The nurses in O'Connor and Jeavons' study worked in a variety of areas in the hospital and had a wide range of qualifications. Death, violence, and extreme challenges in caring for particular patients, were all common critical incidents identified in the three different samples of hospital nurses (Appleton; Burns & Harm; O'Connor & Jeavons).

The above investigations revealed what hospital nurses appraised as critical incidents. In order for the nursing community to understand and respond to critical incidents and the stress that is associated with the incidents, nurses need to explore what is perceived as a critical incident within their area of practice. The purpose of this study is to explore and describe how home care nurses appraise, react to, and cope with critical incidents.

Method and Findings

A descriptive, cross-sectional, retrospective design was used to guide this study. A potential convenience sample of 165 home care nurses were given three months to anonymously complete the four data collection instruments: Participation information sheet (Appleton, 1992b) (revised with permission), Critical incident information form (Appleton, 1992a) (revised with permission), Emotional appraisal scale (Folkman & Lazarus, 1986), and revised Ways of Coping Scale (Folkman et al. 1986). Twenty-five questionnaires returned were appropriate for the study. Qualitative data was coded and descriptive statistics calculated. Content analysis identified six categories of critical incidents. The patient death category was used for incidents where a client death was particularly stressful to the nurse either because of the circumstances surrounding the death or the reactions of the family and friends. The abuse category includes all incidents in which the nurse was subject to verbal aggression, physical threats, or written intimidation from a client or other members of the client's family. Sexual harassment is used to categorize all incidents in which a client or family member displayed behaviours with overt, unwelcome sexual connotation. The urgent situation category includes incidents in which a nurse experienced an unexpected event that required the assistance of emergency personnel due to the haste required to react and the limitations of the nurse's own abilities. The organizational limitations of care category were incidents associated with ethical distress when the nurse's ability to provide appropriate client care was negatively impacted due to organizational factors that exceeded the control of the nurse. The potential threat to personal health category includes all incidents in which a nurse is in actual or potential contact with infectious bodily fluids.

Patient Death

Six critical incidents where included in this category and five of the six incidents in this categorization involved clients receiving palliative care. The situation surrounding the death was either particularly traumatic for the caregivers or the client and/or had great significance to the individual home care nurse. This resulted in the client's death being perceived by the nurse as a critical event. Several nurses reported that the worst part of the critical incident was the unexpectedness of the death, even though the client was receiving palliative care. The unexpected death could be associated with a loss of professional control.

Abuse

Five of the written descriptions were classified under the category of abuse. These incidents constituted a range of events, including both verbal and physical actions. One home care nurse was yelled at by a patient during a visit and another nurse was yelled at over the phone. Another client threatened to hurt the home care nurse during a visit. In all of these reported incidents the nurses felt that the clients had overstepped the boundaries of the nurse-patient relationship; a relationship that ought to be defined by mutual respect and consideration. One nurse described a scenario where she felt both verbally abused and physically threatened by the client's caregivers. Nurses in home care work with a variety of clients and are required to enter the patient's domain where events and incidents can be distorted and the nurse does not have the safety of calling in a co-worker when he/she feels discomfort with a particular situation.

Sexual harassment

Vulnerability is exceptionally relevant to home care nurses who experience situations involving inappropriate sexual behaviour. There were four examples of incidents of sexual harassment that were appraised as critical for the home care nurses in this investigation. One nurse reported feelings of shock and fear with her experience when the front door was blocked by four naked young men when she went to leave. This nurse was exposed to great risk and would have been utterly defenseless if the young men had decided to attack. Home care nurses do not expect to be assaulted when they enter a client's domain. Another home care nurse expressed feelings of unexpectedness at the actions of a patient's family member when he pinned her against the door and attempted to kiss her during a bereavement visit. These descriptions were categorized as sexual harassment, rather than as abuse, due to the extreme sexual connotation involved in the incidents. A third nurse conveyed feelings of personal violation when completing a routine dressing change, a man grabbed her breasts. The fourth nurse described a sexual harassment incident when she visited a male client for routine wound care. On the client's walls were photos of naked women and his questions were personal and unwelcoming. The nurse reported feeling unsafe and powerless which reinforces the vulnerability of home care nurses.

Urgent situations

There were four critical incidents that were classified as urgent situations based on the descriptions provided by the home care nurses. Because of the nature of the situation, the nurse was required to call on help not routinely used or to take measures to gain entry to the home that in ordinary situations she would not use. The home care nurses identified feelings of being alone and feeling helpless in these situations but realized that extraordinary actions were required. In one instance, the nurse felt powerless to help the client and sought appropriate assistance, only to be ridiculed by the family for her decisions. In another event, the nurse reported that during the situation it occurred to her a stab wound may not have been self inflicted and the nurse may have been in danger if there was another party involved with a weapon.

Organizational limitations of care

Having the appropriate level of care for a client can be an important safeguard against a critical incident occurring. However, for a number of reasons this may not always happen. At times the client situation is not always assessed correctly and then the client is not offered the appropriate level of care. Occasionally it is because of unavailability or shortages of services in the health system. Other times it is the result of a lack of communication or poor communication regarding the required level of care. Regardless of the reason, these critical incidents were termed *"organizational limitations of care"* because it is some factor in how the care was organized that led to the incident and left the nurse not prepared. Three nurses identified critical incidents that were associated with limitations of care due to the organizational structure of the health authority in which they worked.

In two situations in this category, the situations involved poor communication between the acute setting and the community, resulting in the nurse experiencing ethical distress as it related to perception of what constituted appropriate client care. This situation was critical for the nurse involved because she experienced helplessness and a loss of control when the young client who was dying was sent home without supports in place. Not only were there no resources ready for the client to be back at home, but in addition the family's perception of the client's prognosis was misunderstood. The family's misunderstanding of palliation intensified the nurse's distress.

Potential threat to personal health.

From an occupational health and safety point of view nurses are exposed to a number of risks that would put their own health at risk. With the potential for contracting hepatitis and other infectious diseases, nurses need to observe cautions to protect their physical health. Despite this practice around observing caution, accidents can still occur. The final category of critical incidents described by home care nurses is potential threat to personal health. Three of the critical incidents were categorized as potential threat to personal health as they involved potential or actual needle stick injuries.

Along with a description of the critical event, nurses were asked about their physical and emotional responses during the days following the event. Nurses reported physical and emotional reactions in the days following the event. Fifty-five percent reported fatigue and insomnia. Eighteen percent reported nausea, headache and other physical symptoms. The emotional reactions of the home care nurses were evaluated using Folkman and Lazarus's Emotional Appraisal Scale (1986). The emotions that were experienced the most intensely by the home care nurses came within the disgusted/angry scale. The second group of emotions that were experienced the most intensely by the home care nurses fell within the worried/fearful scale. The strategies home care nurses used to cope with a critical incident were quantified using the Ways of Coping Questionnaire (revised) (Folkman et al., 1986). The home care nurses reported coping methods during the first few days and evenings following a critical incident. The four coping subscales used the most by these participants in descending order of use were seeking social support, planful problem-solving, self-controlling, and positive reappraisal.

Discussion

There may be many factors depending on the category of event that contribute to a home care nurse appraising an event as critical. Due to the intimate nature of palliative care work, home care nurses spend significant time and energy working with clients in need of palliative care and with their caregivers. When the death does not go as anticipated or there is significant grieving or remorse on the part of the caregiver, this can be emotionally stressful for the home care nurse.

There are particular aspects to home care nursing that may increase the potential exposure to abuse or sexual harassment as a critical incident. For example, the isolation experienced by the home care nurse may increase the perceived risk of threat from the actions of clients or their caregivers as the nurse is not in direct contact with other health care members. Equally important is the fact that nurses working in the home care environment do not have the social support from coworkers that could mediate the effects of the clients' actions (Büssing & Höge, 2004). While patient abuse does occur, some reports can be unfounded and one of the respondents noted that she/he was accused of abusing a patient. This type of incident, which threatens the professional reputation of the nurse, is also at risk of increased occurrence due to the isolation of the nurse in this practice.

Urgent situations differ from those identified as emergency situations in hospital because of the lack of direct support available from other health care professionals. The nurse in the home environment may feel vulnerable due to isolation from colleagues. In addition, the nurse may not be able to control the situation to the extent he or she would be able to exert control in a hospital setting. For example, home care nurses are not privy to the resources that hospital nurses have in urgent situations (i.e., crash carts and readily available trained personnel). Home care nurses may lack the competence or confidence to perform certain tasks or assessments required in an urgent situation.

Ethical distress was identified in the category of organizational limitations of care. The nature of home care nursing practice dictates that the nurse has to be self-reliant and competent in critical thinking. Home care nurses are expected to be self-sufficient because they cannot rely on others during the visit to the client's home. The home care nurse is expected to be autonomous in his or her practice because he/she is required to independently make decisions regarding their client's care. Therefore, if an organization's policies place restrictions on a nurse's practice, the nurse may experience increased feelings of isolation and distress when they are forced to challenge the policies that are in conflict with values or beliefs held by the nurse. The home care nurse feels intense pressure to *"fix"* the problems that the organization had created.

The study has focused on how home care nurses appraise, react and cope with a critical incident. Exploring what a home care nurse appraises as a critical incident is an important aspect in learning what type of traumatic events might be preventable. Acknowledging and understanding the home care nurses' individual reactions and coping strategies after they experience the critical incident is crucial to support them in dealing with the traumatic event.

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Learning objectives

1. Home care nurses who work alone experience violence in their clients homes.
2. Violent incidents have a physical and emotional impact on nurses.

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The perceived impact of external workplace violence. A Retrospective evaluation

Poster

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Focus: Research

Abstract

Background and context

During the 2007-2012 period, about 5000 incidents of Workplace Violence against Catalan health professionals were notified on-line through the Occupational Violence Questionnaire incorporated into the Website www.violenciaocupacional.cat. The reference population of the study consisted of about 40,000 professionals employed in a network of 73 health centers. This information was used to develop a descriptive map of frequency and type of Workplace Violence incidents.

Verbal abuse was reported in 80% of these incidents, often as preceding and accompanying physics and other forms of violence. 30% of assaults included physical and 15% other forms of violence. The patients starred in the attack by 70% of cases. 35% of offenders were recidivist. The attack was attributed mainly to deficiencies in the quality of 'assistance', 'treatment' and 'information', and also to the excessive 'waiting time'.

Only 0.5% of assaulted professionals needed to resort to temporary disability. But 44.5% of them reported having immediate psychological impact of various kinds: somatic, emotional, cognitive, and behavioral. And 40 % of these victims believed that their experience of Workplace Violence will have negative consequences in the medium term on the dynamics of their healthcare work and on their working environment.
The cross-sectional design of the study did not allow knowing the possible medium-term psychosocial consequences of aggression on the offended. The objective of this present research is to explore the perceived impact of violent incident on personal, professional and working experience of the victim of assault.

Methodology

In this exploratory research participated, voluntarily and with informed consent, 89 nurse practitioners (over 90% women) who, between 2010 and 2011, in the crossover design study, had reported psychological effects of an incident of workplace violence. These people answered online the Perceived Impact of Occupational Violence Questionnaire that includes scales on Perceived Violence, on Working Conditions and on Labor Wellbeing.

Findings

Those who perceived a High Intensity of Workplace Violence tended to differ significantly from the group of Low Intensity in the following main aspects: (a) a more negative assessment working conditions and quality of working life in general, (b) a less positive view of the changes taking place in own working experience, professional practice and quality of assistance provided, (c) a greater desire to change of job, (d) lower scores in areas as working wellbeing, job satisfaction, and hope in the own professional future and (e) higher scores on scales of somatization, exhaustion and alienation.

Implications

Workplace Violence impacts negatively the experience, perceptions, attitudes, expectations, and behaviors of victims, affecting the quality of their working life and of the service they provide. And these effects can be foreseen and should be prevented.

Learning objectives

1. To demonstrate the magnitude of workplace violence against Catalan health professionals.
2. To demonstrate how workplace violence impacts negatively the experience, perceptions, attitudes, expectations, and behaviors of victims, affecting the quality of their working life and of the service they provide.

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Supporting staff following a violent incident

Poster

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Focus: Organizational

Abstract

Issue

Following the Institute of Medicine report To Err is Human (Scott et al., 2009) patient safety initiatives have flourished. Improved understanding of adverse events, their impacts and contributory systems issues (Schwappach & Boluarte, 2008) have been paramount and patient centered care has been widely embraced. Less frequently explored are the impacts of adverse events on health care professionals (HCP). Endress et al., (2011) suggest HCP involved in adverse events experience helplessness, depression, feelings of guilt and inadequacy. Although offering staff support has been described as a moral obligation (Denham, 2007) requesting help by the HCP remains fraught with stigma (Endress et al., 2011) and concern for potential breaches of patient confidentiality.

Approach

Trained peer support teams can help mitigate stress experienced by HCP, encourage team communication and contribute to quality patient care. Our team provides confidential services accessible to all staff. The team is comprised of mental health nurses with advanced level training who lead the services which can included debriefings, defusings or one to ones. The team also includes peers from various disciplines who participate as facilitators in collaboration with the Mental Health nurse lead. All team members volunteer their time to provide services and to engage in ongoing team meetings.

Outcomes

Our team has been supported by the executive leadership of our organization since 1994. We provide services to approximately 193 staff members annually. Consistently, themes which prompts calls from staff include; the death of a child, an unanticipated patient death and violence.

Conclusion

Offering staff support following stressful events in the workplace is an important component of a violence prevention program and contributes to overall staff wellness. Acknowledging staff experiences and offering support recognizes that quality health care is best achieved by addressing patient and staff factors.

Learning objectives

1) To discuss staff support as an important factor in workplace violence.
2) To demonstrate the possible barriers health care professionals face when considering formal support.

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Psychological violence and group interpersonal relations in university students groups

Poster

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Focus: Research
Keywords: Psychological violence, intolerance, cynicism, aggression, hostility, status

Abstract

The psychological health of human being is a complicated phenomenon which depends on many different factors. One of them is the quality of interpersonal intragroup relations. Interpersonal relations manifest themselves in the statuses which any student can get in his/her educational group.

The main questions of our study were: Are the different kinds of psychological violence the predictors of students' statuses and which type of this influence (positive or negative) we can find? The answer to these questions is an important symptom of intragroup psychological health because links between violence and higher statuses demonstrated asocial group-activity (Greenblatt, Moreno, A. Petrovsjkyi, M. Kondratiev & et al.). On the contrary, the psychological health of intragroup relations is connected with a low level of violence and lower psychological violence, the higher in-group mood, atmosphere and psychological health of the group's members (May, Moreno, Rogers, Myasishchev & et al.).
We investigated such kinds of psychological violence as communicative intolerance, cynicism, aggression, hostility. We wanted to find the influence of these personality traits on intragroup relations and informal power, sociometric and referentometric students' statuses.

The sample consisted of 204 university psychology students of the first, the third and the fifth years; aged from 17 to 24; 157 females (78%) and 47 males (22%). Data were collected via Sociometric (Moreno) and Referentometric (Chedrina) procedures, Power structure (Kondratiev), Questionnaire of Communicative Tolerance (Boyko) and the Cook – Medley hostility scale. The data were collected by I. Vagurin and author.
According to the results of descriptive statistics the level of some investigated characteristics of psychological violence was within the mean significance (cynicism: M=61.3%; aggression: M=58.3%; hostility: M=65.6%). We found that the score of the hostility was a little higher than the score of the cynicism and the aggression. But the mean significance of communicative intolerance was more than the tendency to the communicative tolerance (M=48.03; the normal communicative tolerance for students is less than 45). All factors (characteristics) of psychological violence (intolerance, cynicism, aggression, hostility) had direct significant correlations between each other ($p \leq 0.01$) and these factors had inverse significant links with different types of statuses.

Then we used the regression analysis in order to study impact of these factors on statuses. The results of this analysis showed (that) only communicative intolerance was predictor of the lowering of all statuses types ($p=0.000$). Aggression and hostility were included in the model as predictors of communicative intolerance ($p=0.001$; $p=000$). Therefore we concluded that cynicism, aggression and hostility weren't predictors of any student's statuses in the educational group. At the same time aggression and hostility were mediators for communicative intolerance as statuses predictors lowering every kind of status.

For discussion we would like to name two main limits of our study: The absence of the concrete traits of psychological health in the studied problem and comparative analysis of student's group with low, middle and higher statuses taking into account all investigated characteristics. The current research showed the importance of low level of psychological violence as the factors of positive statuses in student's educational group.

Learning objectives

1. To demonstrate connections between some characteristics of psychological violence and in-group students' statuses.
2. To provide the participants with the idea that positive atmosphere in students' groups exists when students with higher statuses very rarely use psychological violence in educational groups.

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Promoting civility: An opportunity to improve psychological safety in a healthcare organization

Paper

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Focus: Organisational
Keywords: Psychological safety, civility, Nanaimo Regional General Hospital, healthcare, safety

Issue statement

Respectful and civil behavior is the foundation of a quality workplace and quality healthcare. Inappropriate behavior such as bullying or harassment negatively affects individual and team morale, our ability to work collaboratively and safely to provide quality care.

Background

Inappropriate behavior was identified as a barrier to safety in the evaluation of staff safety activities in the Vancouver Island Health Authority (VIHA). As a result of these findings, psychological safety emerged as an issue to be addressed in the Staff Safety Strategy. The Joint VIHA Unions Health and Safety Committee commissioned a working group to draft a discussion paper to define the issue, explore the literature and available resources and make recommendations for action.

Inappropriate behavior includes a continuum of behaviours such as: incivility, disrespectful behavior, unprofessional conduct, bullying, aggression, threats and violence. Anderson and Pearson (1999) introduced the concept of the incivility spiral. They theorized if incivility goes unchecked, behaviours escalate to bullying, discrimination, harassment and physical violence. They reported the tipping point between incivility and violence is where the intent to harm is no longer ambiguous. Hutton (2006) proposed that mitigating incivility could interrupt this spiral affect and improve health and safety outcomes in the healthcare sector.

Like many industries, healthcare is undergoing rapid change and inter-professional teams are challenged to meet increasing demands, new technologies and new ways of working together. These factors can contribute to increasing conflict, create tension and inappropriate behavior. While it is difficult to quantify these behaviours, the literature cites the prevalence of bullying among nurses and other health care providers noting the negative impact on safe, ethical patient care, staff safety, recruitment, retention, productivity, worker engagement, creativity and learning. We believe respectful and civil behavior is the cornerstone for a psychologically safe and ethical work environment.

VIHA has implemented a number of measures and have a variety of structures in place to address inappropriate behavior in the workplace including:

- Respectful Workplace policy
- Whistle Blowing policy
- Code of Conduct
- VIHA Ethics Services
- Peer Mentoring Program
- Principles Governing Partnership Agreement (For Physician's privilege contracts)
- Learning and Development courses (Respectful Workplace; The Foundation, Conflict Management, Team Building, Leading in a Learning Organization.
- Employee Family Assistance Program (EFAP)

In addition, many employees are governed by professional regulatory bodies and employers must meet legislative requirements including the labour code, human rights act and WorkSafe BC regulations defining appropriate conduct. Collective agreements include language that articulates the shared responsibility of creating harmonious workplaces as well as articles to address harassment and discrimination. Violence prevention is also a required organizational practice through Accreditation Canada. They include measures to prevent worker to worker harassment, aggression and violence in their standards.

Despite the presence of these measures, we continue to receive reports of inappropriate behavior. While it is difficult to prove a causal relationship between these behaviours and indicators such as sick time rates, injury rates, and patient incidents, the evidence in the literature supports a correlation between interpersonal behaviour and overall safety and well-being.

Methods and results

A working group was commissioned by the Joint VIHA, Unions Health and Safety Steering Committee to define the range of inappropriate behavior and psychological safety to make recommendations for actions. The

group met over 7 months culminating its activities with a one day developmental meeting with strategic VIHA leaders and key representative stakeholders. The proceeds of these meetings confirmed a number of fundamental principles and identified strategic interventions that could be incorporated into VIHA operations to build capacity and foster a culture of civility and respect.

Key fundamental principles identified were:
- We all own and must take responsibility for ensuring a psychologically healthy workplace – the issue is not the sole purveyance of one person, one department one program.
- Leaders play a vital role in modeling exemplary behavior and setting behavioral expectations. Resources that support and build capacity in our management team will effectively ensure a psychologically healthy workplace.
- Psychological safety must be integrated throughout the organization and imbedded in other workplace initiatives to ensure organizational uptake.

The working group had representation from our union partners, quality and patient safety, nursing research, occupational health and safety, operational leaders, people and organizational development and our respectful workplace specialist. The process for developing the discussion paper included:
- Conducting a literature review
- Conducting an internal and external environmental scan
- Researching intervention option
- Analysis of intervention options
- Developing criteria for recommendations
- Final recommendations

Sample of Literature Reviewed

Definitions of Psychological Safety

Guarding Minds at Work (GM@W) suggest providing psychological safety at work requires reducing the risk of injury to mental well-being, *"taking precautions to avert injury or danger to employee psychological health"* (2011 p. 1). GM@W identifies 12 psychosocial risk factors impacting psychological safety. They include job fit, involvement and influence, workload management, balance, recognition and reward, support and engagement. Civility and respect are identified as one variable in creating psychological safety.

Edmondson (2011) describes psychological safety in the context of team learning and relates it to the ability to take interpersonal risks where people have *"a sense of confidence that others will not embarrass, reject or punish someone for speaking up"*. It requires a level of trust, caring about each other and respect for each other's competence.

Prevalence and Impact of Inappropriate Behaviour

"Empirical research suggests that employees targeted with uncivil behavior show greater job stress, cognitive distraction, psychological distress, as well as lower job satisfaction and creativity" (Cortina & Magley 2009, p. 272). Porath and Pearson (2010) stated the effects of incivility were far from trivial and in a national (US) poll of managers and employees found 96% of employees had experienced workplace incivility resulting in:
- 48% intentionally decreased work effort
- 47% intentionally decreased time at work
- 38% intentionally decreased work quality
- 80% lost work time worrying about the incident
- 63% lost time avoiding the offender

Causes of Incivility

Clark and Springer (2007) identified high stress work environments, lack of professional, respectful conduct, lack of responsiveness, and arrogance as possible causes of incivility. Healthcare work environments are consistently described as stressful due to workloads, the pace of change in organizational structure, knowledge and technology, resulting fatigue and exhaustion. The complexity of teams and the intricacies of communication, status and hierarchy can also increase the chances of interpersonal conflict particularly if there are mismatched team members, turf wars or lack of tolerance for diversity. Downsizing, layoffs and budget constraints are also cited as causative factors (Nembard and Edmondson, 2006, Spence, Lashinger, Leiter, Day and Gilin, 2009, Hofmeyer, 2003).

Organizational Values

Altuntas and Baykal (2010) reported organizational trust among nurses positively impacted their organizational citizenship behavior (OCB) defined as *"individual behavior that is discretionary, not directly or explicitly recognized by the formal reward system, and that in the aggregate promotes the effective functioning of the organization"* (Walumbwa, Hatnell & Oke, 20101, p. 519). They found nurses who trusted their managers and organizations demonstrated behaviours of *"conscientiousness, civic virtue, courtesy, and altruism more frequently"* (p. 186). These behaviours align with civility and respect.

Impact and Role of Leaders

Nembhard and Edmondson (2006) identified healthcare leaders who have the ability to be inclusive, recognize the contributions of all providers regardless of professional status foster psychological safety and promote engagement in quality improvement work. They note the *"increasing knowledge, specialization and interdependence"* (p. 942) in complex health care teams challenge the traditional hierarchical structures where higher status individuals dominate and lower status employees perceive a risk or fear negative consequences for speaking up. It becomes the leaders role to purposely *"invite team members' comments and to appreciate those comments overtly"* (p. 959).

Personal Responsibility

The literature reviewed consistently reports a general decline in civility in society. While leaders have a significant role to play in creating a culture of civility, each individual must consider what role they play. This requires self awareness, emotional intelligence, time to reflect on personal behavior and the impact it has on others. In addition to technical skills and ability, taking personal responsibility for the quality of interpersonal relationships at work needs to be a valued competency for work performance.

Options Analysis

The literature review and environmental scan identified a number of intervention options. The working group chose 5 potential options for further analysis. They developed a criteria and ranking system to evaluate the programs. A group of 20 leaders, stakeholders, union representatives and working group members assembled to spend a day analyzing the external programs offered to organizations to address psychological safety. The day also included presentations and discussions about current VIHA initiatives, the opportunities and benefits of integrating psychological safety and its interdependence with many of our key quality initiatives.

Guarding Minds @ Work (GM@W) was identified as the most applicable intervention for VIHA use. The program is free, Canadian-based, health care applicable and offers the most comprehensive package of systematic supports to enable employers to develop and continuously improve psychologically safe and healthy work environments.

Other specific action recommendations made were:

- Establish expectations that all VIHA staff, physicians, volunteers and contracted service providers demonstrate psychologically safe behaviours, in everything we do.
- Revise the new employee orientation, violence prevention curriculum, respectful workplace training, Leading in a Learning Organization (LILO) and other relevant learning opportunities to include psychological safety in the curriculum.
- Identify the specific competencies in the leadership framework to support psychological safety and clearly articulate the performance expectations for those competencies.
- Assist front line leaders and all individuals in building capacity to model, promote and plan for a psychologically safe workplace.
- Ensure hiring and promotion interview practices include questions to assess 'fit' with organizational values and competencies to promote psychological safety in the workplace.
- Groups in VIHA who support front line managers become competent in psychological safety concepts and accessing the resources available through Guarding Minds @ Work, CREW and the course offerings from the Institute of Healthcare Communication.

Conclusions and discussion

VIHA has traditionally focused on physical health and safety activities for its most valuable assets, its people. The concept of psychological safety is relatively new but as our awareness grew, it became a key ingredient for a number of system wide strategic initiatives. As the working group explored this issue, it became apparent psychological safety is a foundation for teamwork, learning, safety for both staff and patients and a quality workplace. There is an urgent need to incorporate psychological safety in the workplace to ensure a successful future, reduce absenteeism and injuries, improve morale and productivity, meet emerging legal requirements for Canadian employers and it's just the right thing to do.

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- Sherry Parkin: Violence Prevention Advocate BCNU
- Timothy Orr: Director Residential Care Services

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Learning objectives

1. Defining the positive behaviour you expect versus intervening to correct inappropriate behaviour is a proactive approach to creating psychological safety.
2. Psychological safety supports organizational health and safety and learning.

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The day the drug dealer arrived at the General Hospital of Queretaro bishier

Paper

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Focus: Research

Abstract

Queretaro is one of the most security states in Mexico. Over the narco-traffic and the violence that exist in this country for ten years ago, Queretaro in a exception, almost an oasis in the sea of violence on national level. In June, 2010, an army fight involving shooting left 3 wounded, one dead, and 6 captured. The wounded were taken to the General Hospital of the city. The army took the General Hospital. The streets around were closed and in the circumference of 2 kilometres there was no circulation of traffic. The people were unable to access this zone, the hospital included because not received any patient. The first aids were transferred to other hospitals.

Within 36 hours, the hospital was attended by only 4 persons (the drug dealers). The army patrolled the streets and the soldiers of specials units for the war of drugs were the only visitors that stayed in the hospital. Of course, there were too, doctors, nurses, phamacists, technical laboratory personnel, and secretaries. The medical students and the cleaning workers had rest.

This work studies that the personal of the hospital lived into the fear and the climate of war created by the drug dealer and the army. The impression of work in state of site. Then they said that this it is not only because always the prisoners of the jail have theirs clinical test, they are take the hospital for their attention. These moments are very difficult for workers of hospital because the building is closed and the atmosphere is heavy, similar to the drug dealers day.

This paper included the laboral condition by the situation and expectation of violence in the General Hospital of Queretaro.

Learning objectives

1. To demonstrate that violence emotionally affects the personal that work in the hospitals.
2. To demonstrate that narco-traffic is very dangerous even in one pacific city as Queretaro, and that the situation is worse other cities.

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Psychological impacts and adaptive patterns experienced by nurses working in the workplace of unrest area

Paper

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Focus: Research
Keywords: Terrorism, social unrest, quality of life, mental health, recruitment, retention

Abstract

Human violence or terrorism has been increasing world-wide. Little is known about the impact on the health of nurses who have been working for prolonged periods in areas of social unrest. This study is a part of the larger 2011 project on Quality of Life in the Nursing Workplace, southern Thailand which aims to describe the psychological impact and adaptive patterns experienced by nurses working in 3 identified areas of social unrest in the southern border provinces of Thailand. The method used was focus group, with a purposive selection of 37 nurses. Nursing administrators and nurses in practice participated in 6 focus group discussions using semi-structured interviews. Data were analyzed by content analysis.

Results showed that the psychological trauma experienced by nurses was associated with both internal and external violence. Fear of being unsafe when caring for those injured by terrorism was the most common concern. Three adaptive patterns were noted: 1) sharing feelings and experiences in which their work related stresses were encountered; 2) seeking resources to support mental health; 3) supplementing care with other activities for their survival. The findings could be used to develop strategies to improve nurses' happiness and safety in the workplace. Recruitment and retention of nurses in areas of work stress and social unrest may be improved if they gain optimum and equitable support within a realistic context of care.

Introduction

Human violence or terrorism has been increasing in every area of the world. Since the terrorist events of 2003 in southern Thailand, the threat of terrorism has become a realistic concern for health care workers. In particular, the shortage of nurses in Thailand has been an ongoing concern, especially in areas of unrest in the three southern border provinces of Yala, Pattani and Narathiwas, where significant evidence of the impact of terrorism has been identified. Recruitment and retention of nurses in these areas for any length of time has been problematic.

During events of terrorism, nurses are expected to provide physical, emotional, and psychological support for victims and their families. Nurses experience heavy workloads and continuous psychological stress, endangerment to their health and well-being, and even risk to their lives. However, little is known about nurses' strategies to optimize safe working conditions and minimize their own psychological trauma.

A literature review was performed on the quality of life of professional nurses in Thailand. The studies examined (N= 9) were descriptive, and focused on the quality of the working life of nurses both in university and public health hospitals. Public health hospitals included provincial, general and community hospitals. The results varied widely because of the different types of hospitals and the different research instruments used. The literature suggests that nurses› responses to working long-term in areas of unrest is not well understood and there is a lack of studies regarding nurses› concerns, fears, and anxieties in manmade disasters. Few studies were found to have examined the quality of life among nurses working in areas of unrest in the three southern border provinces of Thailand (Nakpin, 2009; Putachart, 2007).

Aim of the study

This study aims to describe the psychological impact and adaptive patterns experienced by nurses working in social areas of unrest.

Sample

Thai nurses (N=37) were recruited by purposive selection. Hospitals (3) provided lists of potential participants. Inclusion criteria for the study were; nurses had to be working in nursing administration or practice and must have worked more than 5 years in different settings of the 3 areas of unrest in southern Thailand. Participants were informed of the study purpose, that the discussions would be audiotaped, and assured that they could discontinue their participation at any time. Consent forms were signed by each participant prior to beginning the study.

The nurse participants were all over the age of 30 years, most were married, and had worked more than 10 years each. Nineteen (51.3%) worked at community hospitals, 36 (97.3%) lived with their families in their own housing outside of the hospital. Non-married nurses secure living accommodations within the hospital dormitories.

Method

Data were gathered from 37 nurses through 6 focus group discussions using semi-structured interviews. Data gathering and transcription took place simultaneously. To assure confidentiality, each participant in the focus groups and in all audiotape recordings and transcripts was identified by a numerical code. Data was kept in a locked file cabinet accessible only to the primary researchers.
Content analysis of the data proceeded simultaneously by coding and grouping together to form categories. Each transcript was compared and contrasted across groups.

Results

Work related stress was most commonly reported by nurses, but the severity of the stress intensified when they were dealing with the fear of being unsafe in their working environments, particularly in the identified areas of unrest in southern Thailand. Despite their diversity of backgrounds, the participants reflected a commonality in the strategies used for managing work related stress in the workplace. In this study, 3 coping or adaptive patterns were noted: 1) sharing feelings and experiences in their work related stress; 2) seeking resources to support mental health; and 3) supplementing care with other activities for their survival.

1.	**Sharing feelings and experiences in their work related stress**
1.1	**Talking with others and taking care of each other** The nurse participants indicated their work stress was related to terrorism when they were on duty such as referring patients or going out to assist an emergent case in the community. The participants often shared their feelings of empathy by talking with others about their concerns. As one participant stated: • *"When the situation (bomb or violence) happened, we felt more empathy. I would call my friends or colleagues who were working on either day or night shift when it was necessary to refer a patient or go out to help victims on the scenes. I would also call some nurses who stayed outside the hospital and needed to come to work on that day, in order to tell them whether it was safe to travel and give them an option for being off duty"* (FGD head nurse 1).
1.2	**Understanding what others do to alleviate or release their stress** Nurses shared that in an uncontrolled situation, complaints and anger may be expressed and may irritate others. Some nurses said that they would share their understanding of what others did to release their stress. It would help by enabling reflection upon themselves to be more empathic for those who did feel stress and anger. As one participant said who shared her experience in working with the health care team: • *"Most of the time I worked with doctors and others in the hospital. I understand them because they sometimes want to do things better to control the situation, or want me to do things quickly and safely, but I did not do as expected in an emergent situation. I tried to understand their emotions at that time"* (FGD staff nurse 1).
2.	**Seeking resources to support mental health** All participants reflected on their experiences of coping with long term stress when working in areas of social unrest and described seeking a variety of resources to support their mental health.
2.1	**Praying for serenity of mind** Religious involvement is recognized as a significant influence in the mental health of persons, especially for Thai people (Prayutto,2009). Some participants would go to pray in front of Buddha images. Having an active Buddhist practice helped them to release their stress. Two participants reflected: • *"Before I start working, I always think positively. I do good things, pray, and focus on Buddhist doctrine and make a merit for our people and clients to support our mental health… When I feel stressed from my work, I sometimes donate food and money to Thai temples, orphanages or homes of elderly. I feel happy and relieved of my stress"* (FGD head nurse 1) • *"I often pray and think of our Buddha, and think about my ability to work for people in the area if I remain alive. I would pray for further living and to be able to survive longer in my work. In addition, I was taught under the Buddhist belief that if something happens, it will happen"* (FGD head nurse 2).

2.2	**Seeking information before going out** Nurses who worked for an extended time in the community developed a close relationship with the people in the community. They then received critical information from the community about when and where would be safe to go out to buy food or make a visit to an area. The observation of any unusual events in the hospital was also considered to ensure safety before nurses went out. • *"I was warned by community people on that day not to go out and visit in the area because it was unsafe. This may be due to our good relationship, so I feel safe and my tension decreases"* (FGD head nurse 2). • *"I observed in the hospital that if there were fewer clients on that day, it would warn us that it would be too unsafe to go out; we may have some terrorist events on that particular day"* (FGD staff nurse 2).
2.3	**Making friends with positive thinking** With regard to stress in caring for patients affected by terrorist events, the study participants tried to cope by using positive thinking. • *"It would increase our stress as we would not know who are good or bad people when they arrive at ER. However, we would treat them equally and be friendly the same way as with other events. We would communicate and provide the best care for them; it would help them to be friendly with us as well. I do share my feelings with colleagues and believe that if we do something good for them, they would not hurt us"* (FGD staff nurse 3).
2.4	**Seeking protective devices** To increase safety during working and reduce their stress reaction, nurses sought protective devices, such as bullet-proof vests, following tragic events. As a participant said: • *"Shielding health care providers from chemical, physical, biological, and radiologic hazards may sometimes be performed by nurses when caring for contaminated or terrorist patients. More protective devices should be provided, and nurses need a light one because the one we had not was not often used because it was so heavy"* (FGD staff nurse 2).
3.	**Supplementing care with other activities for their survival** For their survival in working in areas of social unrest, all participants tried to shift their focus from work related stress by doing several activities to make themselves feel better.
3.1	**Spending time with family in doing enjoyable activities** One of the most frequently reported strategies to reduce stress was spending more time with family on weekends or days off. Participants indicated it was then easier to deal with work related stress. Spending time with family often helped them ignore unavoidable confrontation with work. As one participant said • *"On weekends or days off, I would join the family to do things together as much as possible. I think in a positive way as well after terrorist event. I begin spending time at home rather than going out. It helps me a lot as my alternative way to relieve some work stress"* (FGD staff nurse 3).
3.2	**Doing something else to feel better** To deal with work related stress, the participants used various self-management strategies by doing something else to feel better or more relaxed. Most stayed home to engage in routine, daily activities. As one participant stated: • *"When I get stressed from work, I always find strategies to help me to feel relaxed or reduce my tension. Many activities I do at home, such as watching television, reading a book, listening to music, using internet, cleaning or cooking. During those activities, I can let go of the problem that is stressing me"* (FGD staff nurse 3).
3.3	**Engaging in the parties and trips to other places** Most hospitals in the areas of social unrest arrange parties and trips for staff every year. In addition, some departments or wards arrange these more frequently as part of a policy to enhance happiness and well-being among staff. The study participants had engaged in the parties and trips which helped them to move away from their focus on work related stress and unpleasant feelings to engagement in enjoyable activities. One participant said: • *"I want to avoid my bad tension and stress, I always engage in the ward project in traveling to other places. I feel better. It also helps me to recharge my energy to work and focus on what to do next"* (FGD staff nurse 4).

Discussion

Psychosocial factors at work are generally associated with the interaction between environment and working conditions. The results of this study showed that psychological impacts were associated with both internal and external violence. Fear of being unsafe when caring for those injured by acts of terrorism was the most common

problem. Emergency and community nurses in particular reflected this: Their work in the environment led them to frequent exposure to the victims who were coping with life threatening or traumatic events during patient referring.

Stress conditions for nurses in their workplaces often included threats to their own safety and to the safety of their colleagues, through bio-hazard, terrorism, and mass casualty incidents (Holland, 2008). Nurses not only felt stress and fear of being unsafe when going outside, but also felt stress when exposed to violent patient behaviors (Grange & Corbett, 2002). Feeling helpless and having limited control was also identified due to their inability to prevent the victim's suffering and alleviate the terrorism. Some nurses reported internal and external violence were *"part of their job"* which led to more physical and psychological risk when compared with nurses working in other areas.

The findings showed that nurses working in areas of social unrest cope with their stress in several ways consistent with the prior research of Mimura and Griffiths (2003). However, religious coping by praying for serenity of mind was identified as the approach that can help a person to engage in spiritual actions to attain mental health and peace (Prayutto, 2009). Shifting their focus on work related stress by doing other activities was also found to be a significant approach for all participants.

Recommendations

The study findings could be used to develop strategies to improve nurses' happiness ,satisfaction, and safety in workplaces where they are surrounded by long term stressors of human violence, social unrest, and acts of terrorism. The religious beliefs and practices which are a part of Thai culture, including meditation, could be examined and tested for their effectiveness in alleviating the severity of stress on nurses in any traumatic situation. In terms of workload and working in critical areas of social unrest, nurses should be taken care of by the government to improve their quality of life and assist them in working efficiently and safely. Recruitment and retention of nurses in areas of work stress and social unrest may be improved if they gain optimum and equitable support within a realistic context of care.

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Learning objectives

1. Participants will understand the health impacts of nurses who have been working in the long term of unrest area.
2. Participants will learn strategies for promoting safety workplace and prevent the violence by a stranger.

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Exploring how emergency department nurses perceive and cope with experiences of workplace violence

Paper

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Focus: Research
Keywords: Emergency department, workplace violence, coping, perception

Introduction

Despite the recent scholastic and public interest in workplace violence (WPV), findings suggest that WPV is increasing[6,11] and remains a significant problem in healthcare today. WPV is any physical or verbal abuse, sexual harassment, bullying, or threatening behaviors that occur at work[4,12].

Half of all reported non-fatal occupational assaults and injuries occurred in the social service sector,[10] highlighting that healthcare workers face higher rates of workplace assault than any other industry[6]. Healthcare workers that spend the most time with patients and families, such as nurses, face the highest rates of WPV[5,6,7,9]. Certain areas within healthcare, such as the emergency department (ED), are notorious for high rates of WPV. Half of ED nurses reported experiencing at least one incidence of physical or verbal WPV at work in the past week[3]. With 200,000 practicing ED nurses in the United States alone[13], the number of victims of WPV is staggering.

Victims of WPV may face several potential consequences, many of which ultimately will impact patient care. The aftermath of WPV can be significant and affects not only the individuals involved, but also the workplace and the general public as well. The emotional and personal outcomes of WPV can be devastating and include post-traumatic stress disorder, fear, chronic pain, burnout, quitting work, depression, anger, and suicidal behavior[1]. WPV has potentially serious physical, behavioral, mental health, economic, societal, and organizational outcomes.

While the incidence of WPV in the ED has been well documented, there are still significant gaps in the literature to be addressed. The majority of published work in the area of WPV has been directed at describing acts of WPV[12] or developing interventions aimed at reducing incidence and training staff to respond to events of WPV[6]. While both are important, there is a wealth of information between the description of incidents of WPV and intervention studies. The purpose of this pilot study is to describe how ED nurses perceive and cope with experiences of WPV; by furthering this understanding we will be better able to define outcomes of WPV and guide health policy and future research.

Methods

A pilot study of the principal investigator's (PI) future dissertation work was completed using qualitative categorical content analysis, also known as conventional content analysis[8].

Participants

The IRB at The University of Texas at Austin and the hospital system Office of Research in which participants were recruited approved the study. Participants were recruited by posting flyers in ED staff break rooms and bathrooms in hospitals within Central Texas. To be eligible for inclusion, participants must be self-identified ED nurses that have experienced WPV while working in the ED. Participants were selected through recruitment and completed an informed consent process before the interviews. Two ED nurses were recruited and participated in this pilot study.

Data Collection

Interviews were conducted using open-ended, semi-structured questions with probes. The PI conducted all interviews off the hospital grounds at a convenient time and location selected by the participant. The interviews lasted from 45 minutes to two hours in length and were audio-taped and transcribed verbatim.

Data Analysis

Following transcription of the data, an inductive approach to content analysis was completed following methods as described by Elo and Kyngus[2]. After immersion in the data by reading each interview transcription as a whole several times, the PI then proceeded with open coding, grouping, and abstraction of the data into subcategories

and categories. The co-authors of this study assisted the PI in refinement of sub-categories and categories and incorporation of the preliminary findings of this study to the PI's existing conceptual model on WPV in the ED.

Results

Two ED nurses were interviewed, Nancy* and Frank* (names have been changed). Nancy described herself as *"50 plus years-old"* and had been a registered nurse for 27 years. Nancy worked in her current ED for the past 10 years but had worked in several other areas of nursing prior to her current position in the ED. Frank was 46 years old had been a registered nurse for 15 years, all of which had been spent in emergency services. During his career, Frank had worked at various levels including as staff nurse, manager, educator, flight nurse, and paramedic. At the time of the interview, Frank was working as a per diem staff nurse in multiple ED's and hospital systems. Both nurses described their workplaces, the evolving nature of the ED and their careers, and shared several experiences of WPV while working in the ED.

Nancy and Frank described several events of workplace violence. While his or her stories varied, the common thread of a perception of threat was present with each nurse's account. From sharing high-profile events of WPV in the ED, to recalling what *"could have happened"* in a particular incident, the threat was real. Nancy recalled *"she could have broke my hip, she could have broke my knee-she could have bashed my head into the floor, I was terrified. I was terrified."* When describing the events of WPV, both nurses affirmed that size, strength, and gender matter and can incite or deter acts of WPV. Frank, at 6'5" and 260lbs had significantly different experiences than Nancy who was 5'2" and stout. Nancy replied, *"I'm getting older, you know. I'm past the half-century mark. My knees don't work so great anymore, too many years on the pavement…I'm pretty sure that most of them could take me out if they wanted to."* Frank's said he felt like his size sometimes incited WPV. *"'Oh, that's the biggest guy in the room, he's the one I'm gonna go after.' Honestly, we used to be taught like that as kids, you know, if you're going to get into a fight with a bully, pick the biggest one in the group and go after that one."*

Adaptive coping was described by both nurses as things that I did and things other people did. Each nurse described things they did such as walking away from the situation immediately following an event of WPV, talking a break, a walk, time off work, and even pursuing criminal charges against an assailant. Further, they each described tangible things that other people did for them after events of WPV, like watching their patients for them, calling the police, and physically caring for their injuries following an attack. Nancy recalled after she was physically injured following an event of WPV, *"a couple of the girls took me into one of the rooms-you know, I was kinda dazed…But I remember a couple of girls taking me in and using um, the bath soap to shampoo my hair and get that all better."*

Frank and Nancy each described maladaptive coping as a result of actions of others, namely co-workers and ED management. Both nurses had a difficult time coping with events of WPV when they perceived their peers were minimizing the situation. Frank recalled an incident when a patient had hit him in head but was he not injured and subsequently became the punch line of many jokes at work. *"You know initially I go along with jokes, um, because the way I am, my personality…part of me is like, fine, then next time I'm going to let him hit one of you guys and see how it feels. Yeah, I mean, I'm big, but the second he hits one of the small female nurses, then it's not funny anymore. Well, why was it funny when he hit me? So yeah, I'm a little disappointed in my colleagues that they would just blow it off like that."* Both nurses echoed a sense of nobody's looking out for me. There was a business first mentality on the part of ED management and their ED co-workers didn't always take all acts of WPV seriously and support one another. Frank relayed, *"the business end is leaning way more towards the business and the patient than we've got to keep our staff safe, OK."*

The nurses described long-term coping mechanisms that they used at work to help deter future events of WPV. By responding in a proactive vs. reactive manner, Nancy and Frank felt that they were safer and more prepared. After a triage nurse was shot in the parking lot at work, Frank stated, *"after my experience, I don't go outside and leave the ER when someone says, 'Oh I need a wheelchair'…not unless security is right there with me."* After being a victim of WPV in the ED, both nurses described a sense of being on guard while at work. Nancy described, *"I'm observing, I'm constantly observing. I'm constantly re-assessing. I'm constantly watching. Are their fingers clutched, are they grinding their teeth even though they look subdued? Uh, are they getting ready to attack, are they pacing and agitated?"*

The environment of the ED was something Nancy and Frank both discussed at length, particularly the changes that have occurred. There was a shift in focus of care in the ED, which Nancy described as being more about customer service than patient care. *"Coughs and boo-boos. Coffee, blankets, sugar in your coffee. You know, uh…more like a stewardess, less like a nurse is the environment that they are creating."* Both nurses described a shift in expectations about the nature of the ED both from staff and patients. Frank recalled that, *"I can remember a time when a physical interaction, event, in the ER was a big deal."* There was also a reported shift in population served and the ED is now inundated with *"frequent fliers,"* homeless patients, and psychiatric patients. Frank asserted, *"people are beginning to know that the ER cannot turn you away for anything."*

Nancy's interview was predominated by the reoccurring thread of the psych effect. Of the three events of WPV Nancy shared, all the patients were as she called them, *"psych,"* or mentally ill. She added, *"only the psych patients that I feel threatened with."* Being labeled a *"psych"* patient changed the way Nancy dealt with her patients. She stated, *"the one thing I hate is when a psych patient comes in. I'm like, I roll my eyes, cause here*

we go. I just take a deep breath, and I, I'm a nurse, cause this is what I'm bound to do. If I want to be employed in the ER, this is something I have to deal with."

Discussion/Conclusion

The findings from this pilot study have several research and practice implications. The environment and culture of the workplace of the ED appears to be an important, and under-researched aspect relating to WPV. Studying WPV in the ED in the context in which it occurs may provide new insight to this phenomenon. Additionally, prior experiences of violence may influence perception and coping in the ED setting. More research is needed to explore this connection. The categories derived from this analysis suggest that there are many levels of influence on perception and coping beyond the individual. The nurses described that fellow staff and management played an integral role in their perception and coping of events of WPV. The PI plans a complete a dissertation study building on this analysis to study ED culture that may deter or facilitate WPV.

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Learning objectives

1. To describe findings of how emergency department nurses perceive and cope with experiences of workplace violence by utilizing thick description of categories.
2. To identify areas for future research and modification to the PI›s existing conceptual framework by discussion and feedback with the audience.

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Factors associated with resident aggression toward caregivers in Swiss nursing homes

Paper

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Focus: Research
Keywords: Aggression, residents, nursing home, nursing staff, SOVES-G-R

Introduction and background

Caregivers in nursing homes often experience aggressive behaviour of residents. As Franz et al. (2010) showed 83.3% of the caregivers in German nursing homes have experienced physical aggression and 90.3% have been exposed to verbal aggression during the previous twelve months. Moreover, the results of the European Nurses Early Exit Study (NEXT-Study) have demonstrated that nursing staff in geriatric wards experience the third highest frequency of aggression of all clinical settings with only nurses in psychiatric and emergency wards were more often confronted with aggression (Camerino, Estryn-Behar, Conway, van Der Heijden, & Hasselhorn, 2008).

While caregivers are challenged to implement measures to reduce aggressive behaviour among residents (Zeller et al., 2011), more in-depth knowledge about factors leading to aggressive behaviour of residents is important for the development of such measures. Based on current research in this field it can be assumed that aggressive behaviour of residents towards their caregivers is multifaceted and emphasizes the characteristics of caregiver, environment, and resident (Gates, Fitzwater, & Succop, 2003).

Isaksson et al. (2008) show that caregivers who are more exposed to aggression had higher burnout scores than less exposed caregivers. The study of Gates et al. (2003) showed significant correlations between the incidence of aggression and staffing ratios, age, occupational strain, as well as occupational stressors like role ambiguity and role insufficiency. In the qualitative investigation of Zeller et al. (2011) caregivers assumed that 'working under pressure', 'lack of thoughtfulness', and 'fear of the resident' are factors which influence the relationship between caregiver and resident and may trigger residents' aggression.

Less knowledge is available regarding the influence of environmental factors on resident aggression. A few studies have reported that older people suffering from dementia are sensitive to changes in their environment and that such changes can trigger aggressive behaviour (Hall & O'Connor, 2004). Moreover, mandatory overtime and the lack of time for appropriate support of residents in activities of daily living result in a significantly higher proportion of physical assaults (Tak et al., 2010).

It can be assumed that caregiver characteristics and environmental factors are associated because caregivers shape or create residents' environment due to their way of performing care and other activities in nursing homes.

As residents suffering from dementia often exhibit aggressive behaviour, dementia seems to be the main risk factor in nursing homes (Testad, Aasland, & Aarsland, 2007). Similarly, Voyer et al. (2005) found significant associations between aggressive behaviour and cognitive impairment, male gender, use of neuroleptic drugs, insomnia, physical distress, and physical restraints.

Aggressive behaviour and associated factors have scarcely been investigated in Swiss nursing homes. Therefore, the aim of this study was to explore caregivers' experiences with aggressive behaviour of residents and to identify environmental factors as well as caregiver and resident characteristics related to aggressive behaviour in a sample of Swiss nursing homes.

Methods

Design and Setting

A retrospective cross-sectional survey was conducted with a sample of caregivers working in various nursing homes in the German-speaking part of Switzerland.

Sample

A non-probability purposive sampling strategy by means of an announcement in two national nursing journals was used for the recruitment of nursing homes. In total 21 directors gave their approval to conduct the survey among the caregivers in their institutions. The 21 nursing homes, located in urban and rural regions in the German-speaking part of Switzerland, differed in size between 25 and 705 beds.

Data collection

The study was conducted between November 2010 and April 2011. The data were collected by means of a questionnaire. The questionnaires and written information regarding the study and its aims were sent to the

directors of the nursing homes for distribution on the wards. In 14 nursing homes staff of all wards participated and in seven nursing homes staff of one to three wards. Accordingly, 1,572 questionnaires were distributed to potential respondents in each of the 21 nursing homes.

Instrument

The questionnaire used was the German version of the Survey of Violence Experienced by Staff (SOVES-G-R). This questionnaire was developed by McKenna (2004) and translated into German as well as investigated on feasibility and face-validity by Hahn et al. (2011) in a general hospital. The SOVES-G-R consists of seven sections pertaining to the following subjects: A) staff characteristics; B) experiences of verbal aggression, threats or physical aggression of residents during their professional life; C) experiences of aggression in the last twelve months; D) experiences of aggressive behaviour during the last seven working days, characteristics of the perpetrator and their impairments in activities of daily living, medical diagnoses, the performed care activity prior to the aggression incident, possible triggers and measures to respond to resident aggression; E) questions related to the consequences and burden of experienced aggression on caregivers and available post-aggression support systems; F) documentation and formal reporting-systems for aggressive incidents; G) experiences pertaining to training in management of aggressive behaviour.

To employ the questionnaire in nursing homes instead of hospitals minor adaptations were necessary. The term 'patient' was changed to 'resident', and items related to patients' diagnoses were modified to more specific diagnoses of residents in nursing homes and their cognitive and/or physical impairments. These changes in the questionnaire were reviewed by seven experts in the field of long term-care in nursing homes. They judged the changes as relevant and comprehensible.

Ethical considerations

This study was approved by the ethics commissions of the various cantons of the participating nursing homes.

Analysis

Standard descriptive statistics were used to describe and summarise the data. To identify risk-factors related to experiencing aggression of residents, multilevel logistic regression analysis was applied. Outcome variables were 'experiences of aggression in the past 12 months and in the past week' (yes or no).

Results

Participants

The questionnaire was returned by 814 caregivers from 21 nursing homes giving rise to an overall response rate of 51.8% with response rates varying from 32.6% to 92.5% across the participating nursing homes. The participants were predominantly female (93.2%) and over 46 years old (44.5%). More than 40% of the participants were qualified as registered nurses with over 15 years of experience in health care service. Most participants (58.8%) work full-time and spend over 60% of their working hours in direct contact with residents (72.8%). Less than half of the participants (44.3%) are trained in the management of aggressive behaviour.

Prevalence of aggressive behaviour

Almost all participants (96%) had experienced aggressive behaviour during their professional career in the health care system. Furthermore, 81.6% (n= 656) had experienced aggressive behaviour during the 12-months period prior to data collection. Of these, 76.5% had experienced verbal aggression, 27.6% threats and 54.0% physical aggression.

Factors associated with aggressive behaviour

A multiple regression model was fitted for factors associated with aggressive behaviour experienced during the past 12 months. The variable selection process resulted in a multiple regression model for physical aggression and threatening behaviour experienced in the past 12 months. The factors are described in Tables 1 and 2.

In the final model for physical aggression the predictive variables were educational level of staff, gender, age, and confidence in managing physical aggression. Table 1 shows that trained staff had experienced physical aggression more often during the past 12 months (OR=1.82, $p < 0.05$) than students. As the results show, female caregivers were more often confronted with physical aggression than male caregivers (OR=1.82, n. s.). For staff under 30 years the odds were more than doubled (OR=2.13, $p < 0.001$) compared with staff over 45 years. Confidence in managing physical aggression increased the estimated odds one and a half fold (OR=1.49, $p < 0.01$).

In the model for threatening behaviour (Table 2) the predictive variables were staff educational level and age. Related to the educational level the results show that registered nurses (OR=1.70, $p < 0.01$) as well as trained nurses (OR=1.89, $p < 0.05$) experience more threatening behaviour compared with non-registered nurses and students. The results regarding age are approximately similar compared with the regression model on physical aggression. The odds for staff under 30 years old were more than doubled (OR=2.00, $p < 0.01$, OR=2.04, $p < 0.01$) compared with staff above the age of 30. Environmental factors like support from superiors, reporting systems for aggressive incidents or institutionalised assistance for affected caregivers as well as resident characteristics were not significant factors in the multiple regression models.

Table 1: Multiple regression model for physical aggression in nursing homes in the past 12 months

Variables	OR	95% CI	p-value
Staff education level: non-student vs. student	1.82	1.06-3.03	0.0296*
Staff gender: female vs. male	1.82	0.94-3.45	0.0746
Staff age: under 30 vs. 30-45 years	1.46	0.99-2.27	0.0858
Staff age: under 30 vs. over 45 years	2.13	1.41-3.23	0.0004***
Staff confidence in managing physical aggression	1.49	1.12-1.99	0.0057**

*OR=odds ratio; CI= confidence interval; *p < .05, **p < .01, ***p < .001*

Table 2: Multiple regression analysis predicting risk factors with threatening behaviour in nursing homes in the past 12 months

Variables	OR	95 % CI	p-value
Staff education level: registered nurses vs. non-registered nurses	1.70	1.22-2.37	0.0017**
Staff education level: non-student vs. student	1.89	1.03-3.45	0.0390*
Staff age: under 30 vs. 30-45 years	2.00	1.27-3.13	0.0027**
Staff age: under 30 vs. over 45 years	2.04	1.33-3.13	0.0011**

*OR=odds ratio; CI= confidence interval; *p < .05, **p < .01, ***p < .001*

Discussion

This study underlines existing evidence that aggressive behaviour from residents towards their caregivers is also a significant problem in Swiss nursing homes (Gates, Fitzwater, Telintelo, Succop, & Sommers, 2004; Zeh, Schablon, Wohlert, Richter, & Nienhaus, 2009).

The results of the factor educational level as a potential risk factor for experiencing aggressive behaviour indicate that trained caregivers, particularly registered nurses, experienced more aggression than students or caregivers with lower educational level such as nursing assistants or enrolled nurses. Magnavita et al. (2011) also found a higher risk of physical assaults for registered nurses than for students and explained this difference on the basis of the tasks of registered nurses which entail more unpleasant personal stimulations (e.g. injections or wound care) which may lead to disputes and aggression. By contrast, the studies of Myers et al. (2005) and Hegney et al. (2010) show a higher aggression risk for nursing aides and nursing assistants than for registered nurses. Myers et al. (2005) show a significant association between the physical lifting of residents and the risk of injury, a task which is mostly performed by nursing assistants in the institution where the study was conducted.

The explanations for these contradictory results perhaps relate to different working-conditions in nursing homes, e.g. mentorship programs for students. In Swiss nursing homes all students are accompanied by experienced nurses and are normally not alone in situations in which aggression occurs. In Switzerland it is also common to allocate registered nurses to residents with multiple health problems, and more complex care, or difficult behaviour such as aggression. These contradictory results concerning educational level of caregivers and their risk to experience aggressive behaviour leads to the tentative assumption, that caregivers' experiences of aggression may depend more on the allocation of care activities than on educational level. The more caregivers are charged with basic care activities, the higher the risk to experience aggression from residents.

In our study female caregivers are more often exposed to physical aggression than male caregivers. In contrast, Aström et al. (2002) report that more male respondents experience aggression but Hegney et al. (2010) found no significant difference in reported workplace violence regarding caregivers' gender. A possible explanation for the higher female aggression risk for female caregivers could be that residents possibly have higher respect for male caregivers and are thus less aggressive. A further tentative explanation for the gender difference in experiencing aggression refers to intimate care activities like dressing, bathing, and toileting which are often performed by female caregivers whereas male caregivers are often more involved in management tasks.

Further results of this study show that younger caregivers (under 30 years old) are more often confronted with aggressive behaviour compared with caregivers over 30 years old. This result does not correspond to the studies of Myers et al. (2005) and Hegney et al. (2010) who found no significant association between age and risk of reported aggressive behaviour.

A possible explanation for this difference may be less experience and routine in dealing with difficult or complex resident situations as well as aggressive behaviour at the beginning of caregivers' professional careers. Given that aggressive behaviour by residents is a multifactorial phenomenon triggered by different reasons it is reasonable to conclude that the care of these residents necessitates high abilities in critical thinking and clinical skills (Yeom & Watson, 2009).

The higher risk of experiencing aggressive behaviour by caregivers who feel confident in managing physical aggression contradicts our expectation. Studies investigating the effect of such training programs indicate an improvement in knowledge about aggression and confidence in the ability to prevent and handle aggressive situations (Gates, Fitzwater, & Succop, 2005; Richter & Needham, 2007; Zeller, Needham, & Halfens, 2006). However, there is no reduction in the number of aggressive incidents after the implementation of training (Gates et al., 2005; Richter & Needham, 2007). Richter und Needham (2007) assumed that caregivers trained in aggression management are more aware of aggressive behaviour. A further consequence of training might be that trained staff is more often deployed to situations with aggressive behaviour because of their greater knowledge.

Conclusions

The results corroborate previous international reports of investigations in nursing homes. The identified risk factors are partially in line with similar investigations but we found also contradictory results especially related to trained caregivers as registered nurses who have a significantly higher risk of experiencing aggressive behaviour than students or caregivers with a lower educational level. The fact that registered nurses are more exposed to aggressive behaviour should be taken into consideration regarding their skills in aggression management and their professional tasks or roles in their teams. Based on the results of the present study we can assume that the allocation of care activities, especially basic care activities, is a more potent mediating factor for experiencing resident aggression than the educational level. Furthermore, the increased risk of caregivers who feel more confident in managing aggressive behaviour cast doubts on the content and aims of training programmes as well as to the instruments used to measure the effect of such training programmes. Finally, it was not possible in this study to detect further associations between caregivers' experiences of aggression and environmental factors or resident characteristics.

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Learning objectives

1. Participants are able to appreciate that resident aggression in nursing homes occurs against the background of complex interaction between persons.
2. Participants will become aware of characteristics of caregivers associating with resident aggression as well as with contradictory findings in this research area.

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Chapter 10 - Financial impacts of aggression/violence

Violence de-escalation training for all healthcare staff

Workshop

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Focus: Organisational

Abstract

Healthcare workers are facing unprecedented numbers of escalating behaviors exhibited by patients, family members and visitors. This prompted the need to search for ways to better equip healthcare workers with de-escalation strategies. All training comes at a cost that concerns healthcare administration in an already financially strapped economic time. Therefore, collecting better data related to the frequency of escalating events, and documenting the costs incurred by the escalating events will justify the costs related to the development of de-escalating training programs, the training of staff, and the use of a behavioral rapid response team. Staff satisfaction is expected to increase as empowerment increases with knowledge in how to deal with the escalating behavior. Costs related to violent events should decrease as the number violent events are defused rather than escalated.

Learning objectives

1. To understand the costs to the healthcare organization for loss of employee productivity due to injuries are but a small part of the total costs that are incurred. Education to de-escalate violence requires time and manpower for training, these costs can be minimal compared to the costs from a behavioral emergency.
2. Data collection tools and methods of communicating the results will be explained and the plan for the evidence based project change will be clearly outlined.

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Chapter 11 - Service related impacts of aggression/violence

Assessment of mental health nurses' experiences

Paper

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Focus: Practice

Background

To evaluate occurrence of aggression and experience of nurses in suppressing aggressive behavior in a psychiatric hospital.

Methodology

The object of research nurses, working in the psychiatric hospital X. Research sample consisted of 44 nurses. Research methods questioning. Statistical analysis of data was performed using statistical analysis programme SPSS (12.0 for Windows).

Findings

The most frequent forms of aggression in the psychiatric hospital are verbal aggression (69,7%), humiliating aggressive behavior (53.5%), and threatening verbal aggression (46.5 %). In terms of age and training, significantly more often younger employees (<45 years) experienced mild physical violence and sexual assault than older employees; in comparison with untrained nurses, trained staff more often proposed that they experienced threatening physical aggression and were more often confronted with deductive aggressive behavior, mild physical violence and attempted suicide of patients; The research results revealed that nurses experienced easy physical violence was from 0 to 100 times (average 17.42) and hard physical violence - from 0 to 7 times (average 0.68) over the past year. Only two respondents (4.5%) noted that they had a sick-leave because of occurred aggression/violence cases at work.

Implications for practice

The research ascertained, that employees with bigger work experience (<20 years) more often evaluated the gender of a nurse (male or female), that tranquillizes a patient, than workers with less work experience. Important interfaces were not established while analyzing the frequency of nurses' actions, which had been applied in the face with an aggressive patient over the past year, depending on nurses' age and their training.

Learning objectives

1. Important interfaces were not established while analyzing the frequency of nurses' actions, which had been applied in the face with an aggressive patient over the past year, depending on nurses age and their training.
2. Violence against the nurses in mental hospital is a serious problem.

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Mental health nurses perceptions of aggression in children

Paper

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Focus: Research
Keywords: Paediatric, trauma, aggression, nursing, relational inquiry

This qualitative research explored mental health nurses perceptions of aggression and the relational influences that affect those perceptions. The findings revealed that although the nurse's relationship with the child was central, the participants' relationships with colleagues were more impactful on the perception of aggression, than client factors alone. The system of care and the self were also identified as relationships that contributed to the nurses' perception of aggression.

The literature review explored the phenomenon of aggression in healthcare, including definitions, assessment tools, education, and government, agency and/or regulatory policies influence on nurses' perceptions of aggression. Specific philosophies of care were reviewed that demonstrated reduction or elimination of aggression including trauma informed care (Bloom, Bennington-Davis, Farragher, McCorkle, Martini, & Wellbank, 2003; Huckshorn, 2005). Trauma informed care is relevant as the agency, where this research was conducted, has been working towards implementation of this philosophy (Mulvihill, 2005; Kinniburgh, Blaustein & Spinazzola, 2005; Murphy & Bennington-Davis, 2005, 2006; Blaustein & Kinniburgh, 2010).

The research surrounding aggression is expanding, although *"aggression and its impact have rarely been examined in nurses and other staff working with children and adolescents"* (Dean, Gibbon, McDermott, Davidson & Scott, 2010). Aggression is a primary symptom of children or youth brought to the attention of health care providers (Bor, 2004; Dean et al., 2010). In order to ascertain participants' perceptions, I needed to determine what behaviour they defined as aggression and how they came to that understanding.

There is limited qualitative research focusing on the meaning attributed to aggression in healthcare within pediatric mental health populations. The limited research beginning to appear in pediatric mental health is not specific to nursing, and fails to explore the relational aspects of aggression or perceptions thereof (Dean et al., 2010). The research surrounding aggression is vast and rife with confusion, partially the result of inconsistent and varied definitions. The frameworks that guide these definitions vary from internal or external models, and rarely consider the extent of which relational dynamics contribute to the context of the situation (Nijman, 1999; Nijman, a' Campo, Ravelli, & Merckelback1999; Nijman & Rector, 1999; Duxbury, 2002; Hartrick Doane & Varcoe 2005). A fuller understanding of the factors contributing to aggressive behaviour, including how an understanding of trauma affects the care provided and the care-providers, is needed.

To understand pediatric mental health nurses' perceptions of aggression, I needed to understand the basis from which the participants came to be in the position of observing, participating and contributing to issues of aggression in their workplace. Participant volunteers were recruited via email, poster and verbal presentation. All participants worked with children ages five to ten years, with a minimum for one year. All participants were registered nurses, educated in Canada. The average age of participants was 37 years, with an average of 11 years nursing experience. There were six female and one male participant, which was representative of the overall nursing demographic at this agency. Ethics approval was granted by the governing university and local facility ethics review boards in alignment with the Tri-Council Policies on conducting research.

Relational Inquiry was used as the conceptual framework to guide the research. Relational Inquiry created a lens from which to view how the participant engaged with, and was shaped by, relationships with their clients, colleagues, the overarching system of care, and self. *"Relational Inquiry involves a reflective process"* (Hartrick Doane & Varcoe, 2007, p. 198) that assumes and looks for *"how people, situations, contexts, environments and processes are integrally connecting and shaping each other"* (Hartrick Doane & Varcoe, 2005, p. 51). *"Each person has a unique personal socio-historical location that affects and shapes the personal identity, experience and interpretations…people are both shaped by and shape other people's responses, situations, experiences and contexts"* (Hartrick Doane & Varcoe, 2005, p. 198). While this construct is similar to the situational model, the situational model is limited to the relationship between the health care personal and the client (Nijman, 1999; Duxbury, 2002). The study was, thus, oriented toward illuminating and understanding the complex interplay of relational factors that shaped nurses' perception of aggression in five to ten year old children.

Kvale's Interpretative Methodology guided the data collection and analysis (Kvale, 1996). Two semi-structured interviews were conducted to gather participants' perceptions. Kvale's Interpretive Methodology informed the analysis and allowed creativity in the approach, by using a combination of 'meaning condensation' and 'meaning interpretation' referred to as *"ad hoc meaning generalization"* (Kvale, 1996, p. 203). This interpretive approach interceded with the relational connections within the interviews and the original interview questions.

The results of the findings were categorized into five thematic segments: Physicality: Construction of Aggression; the Participant-Child Relationship; the Participant-Colleague Relationship; the Participant-System Relationship; and the Participant-Self Relationship. Interwoven throughout the themes were the concepts of *"time"* and *"knowledge"*. All aspects of the findings overlapped relationally, as did the embedded threads of time and knowledge. The participants illustrated their perceptions of aggression through examples of interrelated experiences from their practice.

Definitions of aggression within the literature ranged from terminology that described assertiveness through to overt intentional violence. The participants initially struggled to determine a definition of aggression. Most participants looked to the researcher to provide guidance regarding the definition. The majority of participants had not considered or reflected on what behaviours they interpreted as aggression. The participants eventually settled on a concise definition of the female participants' perceived that behaviour became aggression, when the client demonstrated a physical intention to hurt; the male participant disagreed with intentionality, as a necessary component.

In comparing the participants' definitions with the literature, the majority was most similar to Campbell's articulation of aggression *"that an essential element is the intention to harm another either physically or psychologically…"*(Campbell, 1989, p. 20). The male participant's definition fits more with the Taber's Cyclopedic Dictionary of *"a forceful physical, verbal or symbolic action"* (Venes, 2005, p. 56), however, this definition stops short of the harm being inward or towards self. Similar findings were identified in the study by Dean et al., (2010) except that Dean's research did not sort by gender or professional designation. The differentiation between the male and female definitions may be gender related, however it is difficult to ascertain that without further exploration. (Gehart & Lyle, 2001). The participants perceived aggression on a continuum which included agitation. The participants dismissed self harm as part of this definition, and the term violence was never raised.

The participants were well aware of the child factors that increased the potential for aggression, such as psychiatric illness and/or history of a trauma experience. The participants were clear that how they approached and engaged with the child or their family, directly affected the potential for aggression, and felt that the child's triggers could be mitigated (Irwin, 2006). The literature surrounding trauma informed care and engagement of children emphasizes the importance of learning the child's language both verbal and non verbal to be able to work effectively with them, and co-create strategies to assist with self regulation and affect tolerance (Rivard, Bloom, Abramovitz, Pasqualae, Duncan, McCorcle & Gelman, 2003: Brendtro, 2004; Perry, 2004; Blaustein & Kinniburgh, 2010).

The participants perceived that the relationships with colleagues had the most significant impact on aggression in children. Participants felt that colleagues, who interrupted or interfered with the participant-child relationship, affected the dynamics and increased the potential for aggression, similar to a parental relationship. The participants felt de-valued and dismissed by colleagues who interfered. Longevity and years of work experience were not factors in the relational dynamics between colleagues. Communication, respect and shared work values were critical to relationships with colleagues. Participants referred to this collegial dynamic, as 'walking along side'. If colleagues were unable to 'walk along side', and interfered with the participant-child relationship, the child's behaviour was perceived to escalate into aggression. My interpretation is the relationships between colleagues, affected the participant-child dynamic by reducing anxiety in the participant (and child) and increasing their confidence in working with the child. Participants concluded that if they were able to walk along side a colleague, their perceptions and responses to children's behaviour was less intense, more manageable and/or to a lesser degree perceive behaviours as aggression.

The participants identified that physician staff and administrative management, had an impact on their perceptions of aggression in children. A few of the participants reported feeling as if the administration viewed them as 'replaceable' and unvalued. The majority of participants felt content with their work, although this discrepancy raises the question of whether others are feeling discontented. Lynch, Plant & Ryan (2005) connected job satisfaction and job related stress with staff feeling supported at work, satisfied with their ability to control their work environments, were less controlling of clients and thus less reactive. Gill, Fisher and Bowie (2002) indicate that the less supportive an organization is, the unhappier its workers and thus, the more aggressive client behaviours are perceived. Administration and staff members overlook how organizational culture and environmental contexts contribute to aggression. The overall organizational message and leadership presentation affect staff morale, and thus care provided to clients (Paterson, 2006).

As previously mentioned, this agency has been in the process of introducing a trauma informed care philosophy. The participants appeared to understand the affects of trauma in relation to the children, however did not discuss how trauma may have affected them personally or professionally, nor did they refer to it in their colleagues. I did not ask the participants directly about personal trauma however it may be a topic for future research consideration or education.

Relationships are not limited to others; we are also in relation with ourselves. *"Nurses intentionally engage or disengage with people, they are always in relations, and those relational moments are always affecting and shaping the health and healing process to and for others, but equally for oneself"* (Hartrick Doane & Varcoe, 2005, p.175). Self reflection is an important and critical nursing skill that most nurses do not always have the time or opportunity to consciously engage in. The participants demonstrated self-reflection throughout the

research process. For example, the act of remembering various situations, their role, thoughts and feelings, demonstrates an in-depth level of self-reflection. The question of 'did I do enough' was prevalent for all the participants in relation to prevention, intervention, and knowledge with the child and family. This also relates to the participant's feelings of walking along side with colleagues, contributing to self-confidence and competence while caring for the children.

The participants varied in their understanding of their own personal physical and psychological reactions to aggression. Some had done significant work in the area of self-reflection and self-care, however many had not. For some, the research process allowed them the chance to reflect on an experience they previously reported not 'having the time' to do. Self-reflection creates an opportunity to consider the various strategies and options to ensure that they, the participants practice from an ethical framework. Ultimately, the participants recognized self reflection was important to establish an understanding of their role in relational development. These relationships are critical to affecting the dynamics between the staff member and child to either escalate or de-escalate behavior into becoming aggression.

A nurse's self-awareness, perceptions of competence and confidence contribute to the ability to work with clients, colleagues and the organization (Dean et al., 2010). As the staff members' work satisfaction decreases, the ability to be proactive also decreases, resulting in an increase in the perception of a lack of safety (Lynch, Plant & Ryan, 2005). Unfortunately, what often occurs in these circumstances is an increase in staff members' attempts to control and restrict client behaviour. *"Pediatric psychiatric nurses had the highest perceived need for restraints however were least likely to use alternatives"* (Allen, 2000, p. 162). These approaches are often used under the guise of 'safety', however typically create increased reactivity on the part of the client, often resulting in increased aggression (McDonnell, 2006; 2007; Delaney, 2006; Huckshorn, 2005).

There is good evidence that self-reflection, mindful communication, including clinical supervision, reduces burnout and moral distress (Brunero & Stein-Parbury, 2008; Bryant, 2010; Clark, 2010). The participant's ability to self-reflect illustrated a personal awareness, confidence and understanding of how they respond to children's behaviour, in recognizing the potential for aggression. From the findings of this research my primary recommendation is individual and group clinical supervision.

The research identifies that participants perceive aggression on a continuum of behaviour. Perceptions of aggression are directly influence by the relational dynamics between participants, colleagues and feelings of job satisfaction, and confidence in the workplace. The participants' compassion for the children and each other is impressive. All participants desire the opportunity for self reflection in a supportive and safe environment. It would benefit this agency, and others, to create a process of allowing staff, such as nurses, time away from their day to day work to participate in research. This would benefit both the research process as well as the individual participants. The second recommendation is to establish clinical supervision for nursing. Clinical supervision would involve scheduled time with a senior nurse or other, not the direct supervisor, to have time for self reflection and professional development (Fowler, 1996; Landmark, Hansen, Bjones, & Bohler, 2003). The evidence is clear that by creating a place to share and discuss practice concerns, issues of burnout, moral distress, and possibly collegial conflict would be greatly reduced. I also suggest that trauma informed care be evaluated from a systems perspective at this organization, and determine next steps for educational opportunities. Future research would include exploration of perceptions of other health care providers; gender differences; client/family perceptions; evaluation of clinical supervision and its impact on nursing practice.

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Learning objectives

1. Attendees will understand the significance of the effects of relational dynamics on perceptions of aggression.
2. Attendees will recognize the value of clinical self-reflection/supervision in the context of aggression reduction.

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Prediction of repeat visits by victims of intimate partner violence to a level I trauma centre

Paper

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Focus: Research
Keywords: Domestic violence, emergency room, injury, repeat admission, risk factors.

Introduction and background

Services highly utilized by victims of intimate partner violence include hospital emergency departments, which serve as major *"points of entry"* into the health care system.[1] Prompt identification of intimate partner violence victims in the emergency room (ER) has been demonstrated to permit interventions to be initiated with subsequent impact on health problems as well as health care utilization and costs.[2] Aside from needed attention for injuries, qualitative studies have indicated that acknowledgment of abuse and confirmation of the victims' worth by health care providers is a powerful intervention that enables the victim to move toward safety.[3]

The most obvious clinical presentation of intimate partner violence is injury. Studies in Australia and the United States have shown that the emergency department is a common point of entry to the health care system by victims of intimate partner violence.[4-6] In the only Canadian incidence study of intimate partner violence in the ER, 6% of female victims presenting to the ER did so because of sequelae of intimate partner violence.[7] Patients showed repetitive injuries, with about half the patients having more than one injury at presentation.[8]

American studies suggest that 10%-35% of all women presenting to EDS are there because of injury or illness related to chronic abuse.[9-17] One of the few studies looking at male victims presenting to emergency departments reported that 12.6% had been victims of intimate partner violence committed by a female partner within the preceding year.[18] An ER-based study from Sydney, Australia surveying 1169 men and women reported a history of intimate partner violence among 19% of patients.[19] The risk of exposure among females was more than twice that among males RR 2.29 (96% Confidence Intervals, 1.62-3.23). Canadian national surveys have indicated that both men and women are perpetrators and victims of domestic violence but women are more than twice as likely to experience severe violence, including use of a weapon, and five times more likely to receive medical attention.[20]

Australian studies emphasize the pervasiveness and severity of consequences of intimate partner violence. Among 401 women interviewed by Bates et al. in an ER during a five week period in 1992 in a teaching hospital in Newcastle, Australia, 26% reported a lifetime exposure rate to domestic violence.[21] Types of injuries were bruising, fracture and cuts. Eighteen percent of women suffered a fracture in the most recent episode of violence and 55% of women experienced hematoma. In 29% of cases, sexual assault was attempted or achieved. Weapons were used in 20% of attacks.

Studies across the continents have also shown the frequent failure of health professionals to diagnose abuse.[4,6] The detection rates of victims of intimate partner violence by nurses and doctors in the emergency departments have ranged from 5.0% to 16.0%. [4,10,11,16,22] Women arriving at trauma centres for intimate partner violence-related problems have been shown to be more likely to present during the night, when staffing levels are lower, and social workers are often not available to undertake detailed social histories.[23,24] In our preliminary study, persons visiting the ER more than 20 times had, on average, not disclosed violence until the 13th visit.[25]

To cloud the picture even further, intimate partner violence victims suffer from a myriad of health problems that bring them to emergency rooms, including medical, gynecological, or mental health problems.[4,24,26-28] In a population-based study undertaken in Australia, women experiencing intimate partner violence were found to have higher levels of stress, anxiety, depression and other psychiatric disorders.[29] They experienced higher rates of alcoholism, were almost 5 times more likely to attempt suicide and were 9 times more likely to abuse drugs. Thus, an approach to assessment targeting only injured patients fails to identify a significant number of persons who are victims of intimate partner violence. Among women coming to the emergency room specifically because of intimate partner violence in Bate's Australian study, only 23% presented with an injury.[21]

Very little is known about predictors of injurious intimate partner violence. In the Australian studies, there were no significant differences between victims and non-victims in education, religion or employment, although victims were more likely to be under 30 years of age, divorced or separated.[21] An American study reporting on emergency rooms in Denver, Colorado reported similarly that while women with a history of intimate partner violence were younger than non-abused women, no association was found between exposure and ethnicity, education , income, or pregnancy status

Purpose

The overall purpose of this study was to describe and contrast the population of persons presenting to Vancouver hospital emergency departments two or more times in a twelve year period with those who have presented only once.

Objectives

- To compare persons presenting at the emergency room with a history of intimate partner violence exposure who are repeat presenters (> two times) in 12 years versus infrequent (once only) presenters: socio-demographic characteristics; injury profiles and presenting complaints; use of hospital services (admission, length of stay, triage acuity and and services admitted to (eg. orthopedics) among repeat vs infrequent presenters; referrals given to repeat vs. infrequent presenters on discharge.
- To develop a prediction model characterizing repeat visitors.

Methods

Design

This is a retrospective study case control study utilizing data previously collected for routine care at Vancouver General Hospital.

Sample

Subjects for this study have been identified as being exposed to intimate partner violence on at least one vist to Vancouver General Hospital Emergency Department in Vancouver, B.C., Canada during the study period 1997-2009. Vancouver General Hospital Emergency is the major trauma centre for the Province of BC and receives about 80% of emergency room admissions in the city of Vancouver. At Vancouver General Hospital, documentation by nursing and/or medical staff includes assessment for intimate partner violence. Staff receive training in assessing for intimate partner violence as part of their orientation to the emergency room. Inservices are provided on a regular basis by the Domestic Violence Program Director. Patients are assessed in private and documentation takes place on standardized forms. These forms are part of the patient record and a carbon copy is forwarded by health records clerks to the Domestic Violence Program. There, the data administrator enters the data into a relational database.

Exposure ascertainment

Frequent visitors are defined as individuals who disclosed on at least one occasion and who had presented to the ER on two or more occasions. Controls are individuals who have disclosed intimate partner violence on at least one visit and who have presented to the ER only once during the study period. Our choice of a *"cutoff"* of two or more visits is based on the initial observation in our pilot study that 2.5 % of all persons attending the emergency room with at least one disclosure had visited more than two times during a 10 year period. Each person in the domestic violence database has a unique identifier; the medical record number (MRN). Repeat visits are identified through the presence of more than one entry for the MRN. The sequence of visits is identified through dates attached to each visit. With linkage to the VGH emergency room database, using the MRN number, we can identify all of the visits by an individual during the study period, regardless of whether or not intimate partner violence was disclosed.

Outcome ascertainment

The Domestic Violence Record documents sociodemographic varables, nature of abuse including severity, onset, and frequency, use of weapons, ethnciity, psycho-social assessment, police involvement, and discharge teaching, destination, and referrals. Age, length of stay, arrival mode, chief complaint, triage acuity, procedures and services, and status at discharge are present on the emergency room database during the same time period.

Linkage and analysis

Data were extracted from the ER database to a Microsoft Access datafile and merged with the Domestic Violence database using a common unique identifier, the MRN or medical record number. Outcomes among our comparison groups were compared using t-tests for continuous variables and chi-square tests for discrete variables. A prediction model of repeat vs. infrequent visits was developed using logistic regression. Variables were entered into the model one at a time, retaining the one with the smallest p-value, then testing remaining variables in an iterative process until addition of variables did not improve goodness of fit statistics as measured by the model chi square statistic.

Results

Sociodemographic characteristics

Among visitors to the VGH emergency department who were exposed to domestic violence, repeat visitors were more likely to be female with male perpetrators, odds ratio (OR) 2.18, 95% Confidence Intervals (1.20-3.96), to be in a dating relationship compared to married or divorced 1.42 (1.02-1.97), to be First Nations 2.36 (1.78-3.15), to not be of Chinese descent, 0.27 (0.15-0.47), and to be of middle age 2.45 (1.67-3.59), (40-49 vs. 20-29 years of age). They were also more likely to have been abused as children 2.07 (1.40-3.05) and to have had multiple abusers as adults 3.35 (2.30-4.90).

Nature of abuse

Repeat visitors were more likely to have received threats to be killed 2.06 (1.50-2.82), and to have their family threatened 1.96 (1.05-3.63). They were more likely to have had police involvement in previous incidents 2.56 (1.78-3.69) but not the most recent incident. They were more likely to describe the abuse as constant 1.53 (1.10-2.13) compared to unpredictable. They were less likely to report use of a weapon, 0.58 (0.38-0.88). In homes where children were present, Ministry of Children and Family Development was more frequent and victimization of the children less frequent 0.24 (0.06-0.98).

Use of hospital services

Repeat visitors were admitted to the ER at the same rate as single visit victims of domestic violence; however they had statistically significantly longer stays in the ER 408.9 (394.3) vs. 343.6 (394.6) minutes, p=.03. In terms of triage acuity, they were significantly more likely to be classified as emergency vs. non-urgent 2.38 (1.18-4.80). There were more likely to arrive by ambulance compared to walk-in or private vehicle 1.88 (1.38-2.57). Repeat visitors were more likely to present with problems related to addiction 2.54 (1.21-5.33). The major differences in services consulted were higher rates in internal medicine and psychiatry among repeat visitors.

Referrals

While in emergency, repeat visitors were more likely to receive care from the following patient services: internal medicine, and psychiatry. They were significantly more likely to be admitted to a hospital nursing unit 1.47 (1.00-2.17) and to be transferred to a different hospital 5.29 (1.26-22.28).

Predictors of repeat visits

Among all of the variables significant in a univariate analysis, only five remained statistically significantly associated with repeat visits in a multivariate analysis. These were ethnicity;(aboriginal 2.29 (1,30-4.01) or middle eastern 5.07 (1.13-22.7); previous abuse by a different perpetrator, 3.38 (1.88-6.08); lack of police involvement, threat to kill the victim2.98 (1.74-5.08); and chief presenting complaint; mental illness, 3.03 (1.59-5.77). Police involvement was protective against repeat visits; 0.54 (0.36-0.98).

Discussion and conclusions

Our study highlights the potential of health professionals in the emergency room to identify those at risk of repeated violence severe enough to require visits to the ER. If ER caregivers can be persuaded at a minimum to assess and document those individuals at highest risk of ongoing violence exposure, they create opportunities to undertake safety planning and referral. The utility of safety planning in preventing violence has been supported by randomized controlled trials in maternity care settings[30,31] and shelters.[32] Accurate identification of those at risk of repeated violence enhances opportunity to implement effective interventions and referrals with the long term goal of reducing the incidence of injury and other morbidities associated with intimate partner violence

Acknowledgment

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Learning objectives

1. To understand risk factors for multiple visits to the emergency room related to intimate partner violence.
2. To learn the most robust predictors of multiple visits associated with intimate partner violence.

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Violent incidents within psychiatric facilities

Paper

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Focus: Research

Introduction

The literature on violence by psychiatric inpatients provides some evidence that rates of violence may be increasing over time. The violence is the result of an interaction between the various types of factors and is not simply an expression of individual pathology. Aggression and violence are a major problem in acute psychiatric wards, with career prevalence rates of being assaulted approximating 100% for mental healthcare staff. Manifest or impending violence is frequently managed by coercive measures such as seclusion, restraint or forced medication. Reducing the perceived need for coercion and the rate of aggressive incidents would advance the quality of psychiatric care. A prerequisite for adequate prevention is the assessment of high-risk situations. Environmental factors such as overcrowding and staff factors have been linked with violence. This study focuses on the possible complex interaction with these factors.

Methods

Data on violent incidents were gathered prospectively from two acute psychiatric units in two general hospitals and two units in a psychiatric hospital in Isfahan, Iran. Staff recorded violent and aggressive incidents by using Morrison's hierarchy of aggressive and violent behavior. The classification ranged from level 1, inflicted serious harm to self or others requiring medical care, to level 8, exhibited low-grade hostility . They also completed weekly reports of staffing levels and patient mix.
The Ward Activity Index comprised items reported by staff focus groups that increase activity on the ward. Items included total patient numbers, demographic and diagnostic mix, number of new admissions, and the number of patients with a history of violence. The nursing unit manager completed it weekly. Items were summed for a total score per week.

The Staff Level Index included items about factors that enhanced staff members' accessibility to patients; these items, such as the numbers of staff on duty, were scored positively. Some items reflected factors that hindered staff's accessibility; these items, such as staff absenteeism, were scored negatively. Items included the number of rostered staff, years of experience, demographic mix, the actual number of staff on duty, and the use of staff from a temporary agency or replacement staff. The Staff Index Level was completed weekly by the nursing unit manager.

The primary analysis examined violence in terms of incidents per week per occupied bed. Subscales from the Ward Activity Index and the Staff Level Index were extracted using principal components analysis and varimax rotation. Factors that explained substantial variance in the total scores of the respective index were then correlated with the number of violent incidents per unit per week per occupied bed. To examine relationships in stages, patient factors from the Ward Activity Index and staff factors from the Staff Level Index were each considered alone and then combined in a final model.

Formal analysis for the rate of violent incidents was conducted using exact methods via Poisson regression. As the dependent variable was a count, it may be assumed to follow a Poisson distribution. Because the number of violent incidents might be expected to increase with the patient population regardless of any other factor, violence was examined in terms of the rate of violent incidents per bed-week, yielding a Poisson rate. Formal inference was via Poisson regression from which relative rates and 95 percent confidence intervals were obtained, in addition to p values.

Results

Four hundred violent incidents were recorded over a three-month period, which were perpetrated by 74 individuals. Most were rated in the four most serious categories, with one life-threatening incident. Average bed occupancy was 89 percent, with an equal number of men and women. Most patients were between the ages of 26 and 40 years. Half of the patients were involuntarily detained. More than half the patients in each study week had a diagnosis of schizophrenia or bipolar affective disorder.
Most incidents occurred in the morning or evening .Fewer incidents occurred at lunch or after midnight .Most aggression or violence was directed toward staff members, followed by property, other patients, self, family, and visitors. The response to most incidents was counseling. Other responses included medication, removal from the immediate area, physical restraint, and seclusion. Only a few responses involved transfer to a different facility.

Of the 400 incidents identified, 190 were rated as serious and organizational issues were examined. A warning sign, commonly agitation, preceded most of these incidents. Targets of the serious incidents included nursing staff, fellow patients, property, self, physicians, psychologists, family members, and domestic staff.

Three subscales that accounted for 49 percent of the variance in the Staff Level Index were identified using factor analysis. Factor 1 appeared to measure nursing staffing practices. The items that loaded above .5 were the number of female nursing staff on the roster that week, nursing staff without specific psychiatric training, and the presence of nursing staff with specific training in dealing with aggression. The number of students attached to the ward loaded negatively to this factor. Factor 1 had a moderate correlation with the number of violent incidents per occupied bed.

Factor 2 also reflected staffing matters. The three items that loaded above .5 were the number of male nurses, the number of senior nursing staff, and the number of staff members who were less than 30 years of age on the roster that week. The number of male nurses loaded negatively to this factor. Factor 2 had a negative correlation with the number of violent incidents per occupied bed.

Factor 3 appeared to measure staff absenteeism. The number of non-nursing staff on planned leave loaded above .5, and unplanned nursing absenteeism loaded negatively. Factor 3 had a weak positive correlation with the number of violent incidents per occupied bed.

Staff-related factors found by the Poisson regression model to be independently and significantly associated with violent incidents were more staff on duty that lacked specific psychiatric training, students on the ward, more nursing staff on duty (either men or women), more senior nurses on duty, and the planned absence of nonnursing staff. More staff under age 30 was associated with a decrease in the relative risk of violence. Together these factors accounted for 78 percent of the variance in the Staff Level Index.

Factor analysis found two factors within the Ward Activity Index that accounted for 46 percent of the variance in the index score. Factor 1 appeared to measure total ward load. The items that loaded above .5 were the number of occupied beds, male patients, physically sick or disoriented patients, patients with a history of violence, and patients cared for in ward areas with increased security.

Factor 2 appeared to measure the difficult caseload of the ward. The items that loaded above .5 were the number of patients between the ages of 26 and 40; patients with acute psychotic illness, personality disorder, or substance abuse problems; and the number of patients who had been involuntarily admitted. Only factor 1 had a positive correlation with the number of violent incidents per occupied bed (Spearman correlation coefficient=.58, $p<.001$). Factor 2 was not significantly correlated.

Factors from the Ward Activity Index found by the Poisson regression model to be independently and significantly associated with violent incidents were increased number of patients (both male and female), patients detained involuntarily, disoriented patients, increased use of seclusion, more patients in the secure area of the ward, and the presence of known instigators of violence. The following factors were significantly associated with a decrease in the relative risk of violent incidents: patients on the waiting list, physically sick patients, suicidal patients on the ward, and patients who had returned to the ward after being discharged within the last month. The relative risk analysis of patient age groups revealed that younger patients (less than 25 years old) had the greatest negative association with the risk of violence. Together these 15 factors were found to account for 78 percent of the variance.

Finally, items from both the Staff Level Index and the Ward Activity Index were entered into a Poisson regression model to examine the impact of both staffing and patients on the relative risk of violence. relative risk increased with more nursing staff (of either sex), more non-nursing staff on planned leave, more patients known to instigate violence, a greater number of disoriented patients, more patients detained involuntarily, and more use of seclusion. The relative risk decreased with more young staff (under 30 years old), more nursing staff with unplanned absenteeism, more new admissions, and more patients with substance abuse or physical illness. In total these factors accounted for 62 percent of the variance in violence.

Conclusions

Violent incidents within psychiatric facilities were frequent and serious, with great significance for occupational health. Some clues were found in the prediction of violence. Data collected by the hospital administration is likely to seriously underestimate the extent, both in frequency and in seriousness, of violence and aggression in psychiatric services. Based on these findings, several strategies for managing violent behavior in psychiatric settings could be developed. Given that warning signs preceded most incidents, staff training programs could target early recognition of warning signs of violence and aim to institute early verbal de-escalation procedures. A history of violence continues to be a factor that can aid in the early identification at admission of those at risk of violence and aggression. incidents against staff were reduced by identifying patients with a history of violence, making staff members immediately aware of this information, and planning appropriate treatment.

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Learning objectives

1. To explore the incidence and situation, of aggressive and violent behaviors in acute psychiatric inpatient settings in Isfahan, Iran.
2. To evaluate the possible complex interaction between ward staffing, patient mix, and violence.

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Chapter 12 - Professional, legal and ethical impacts of aggression/violence

Similarities and differences in how mental health nurses and police workers handle aggressive client behaviour

Paper

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Focus: Practice

Abstract

Background and context

Aggressive client behaviour is a presenting problem for both psychiatric care workers and police workers. Often the two different occupational groups have to deal with the same clients but in different settings. For example: The police get called to a worried, confused and aggressive fellow citizen who is taken into police custody due to the nature of his behaviour. A medical officer judges the person to be mentally ill and refers him to a psychiatric hospital where the caregivers specialists takes care of him. At this interface the police and the psychiatric nurse worker get in contact with each other. An inspection of the way these occupational groups handle the same challenge reveals similarities and differences. As a policeman with four years of professional experience I was able to work for two months in a psychiatric hospital and observe the way in which mental health nurses handle clients aggressive behaviour.

Methodology

Given the paucity of research findings in this area I conducted several unstructured group and individual interviews with mental health nurses in an inpatient setting. The similarities and differences between the two occupations were inductively derived on the basis of my experience as a police worker.

Findings

The following differences were derived from the interviews with the mental health nurses: The setting in which the aggressive behaviour takes place, the visibility aspect in handling aggressive behaviour, legal consequences of the aggressive demeanour of the client, the nature of the relationship to the client especially in terms of duration and knowledge of the client, the clients attribution of the role of the mental health nurse or the police worker, the professionals the mental health nurses or the police workers perception of the genesis of the aggressive incident, and the physical appearance of the the mental health nurse or the police worker.

The similarities observed include: De-escalation strategies, adequate respect for the client, and adherence to the principle of proportionality.

Implications

The differences in the way mental health nurses and police workers may suggest that clients demonstrating aggressive behaviour are subjected to different types of approaches. An aggressive client who is transferred from police custody to the psychiatric hospital may thus experience some cognitive dissonance. Possibly the two professions could learn from one another and create synergies to ameliorate their approaches to handling aggression.

Learning objectives

1. Participants are able to understand differences and similarities in the way mental health nurses and police workers may typically handle violence.
2. Participants will appreciate that handling aggressive behaviour can be a function of the profession involved.

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Chapter 13 - Creating aggression and violence minimizing cultures

In their own words: A national study on nurses' exposure to occupational violence in Lebanon

Poster

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Focus: Research

Abstract

Background

Exposure to violence is an occupational hazard that plagues healthcare organizations around the globe. There is a consensus in literature that nurses are disproportionally affected. There is a dearth of studies that have investigated nurses exposure to occupational violence in the Middle East region. This study represents a rare attempt to listen to the voice of nurses in Lebanon regarding their exposure to occupational violence and their reported instigators of this violence.

Methodology

A cross sectional design was utilized to survey a stratified random sample of nurses registered with the Order of Lebanese nurses. A random sample of 558 nurses was taken from the 6,579 nurses with reachable addresses. The survey instrument included a number of open ended questions to solicit feedback, anecdotes, suggestions, powerful statements, and recommendations of nurses in regards to their exposure to occupational violence. The data was analyzed using thematic analysis.

Findings

Three hundred forty nurses (59%) completed the open ended questions. Thematic analysis of nurses answers detailed the internal and external causes of violence at healthcare organizations. Internal causes of violence included the organizations physical lay-out, sub-optimal human resources management, poor communication and weak coordination between staff members. External causes of violence were the lack of awareness of the nurses role in healthcare, deficient laws to monitor employment rights, weak syndicates/orders to protect the nurses, ineffective police/security forces to protect the nurses, and patient/families perception that resorting to violence would get their demands answered at healthcare facilities. According to nurses anecdotes verbal, physical and sexual violence were experienced in healthcare facilities not only from patients and their families but also from colleagues and other staff members (horizontal violence).

Implications

The work environment that nurses describe is not conducive to productivity nor does it lead to effective and safe patient care. Nurses describe cases of abuse coupled with denial of basic employment rights. Decreasing nurses' (and other healthcare workers) exposure to occupational violence need to be flagged as a high priority issue for policy and practice. Quick and effective amendments need to be made both internally (within the hospital) and externally to avoid the constantly declining state of healthcare, and to empower, retain, and motivate Lebanese nurses. A series of policy and practice recommendations are outlined for the perusal of healthcare stakeholders in Lebanon and other countries in the region with similar contexts.

Learning objectives

1. Nurses describe a high level of exposure to occupational violence at Lebanese healthcare facilities (verbal, physical and to a lesser extent sexual) with little done to support or protect them.
2. Instigators of violence include a number of factors that are under the control of healthcare managers; including: poor physical lay-out, sub-optimal human resources management, poor communication and weak coordination between staff members.

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Ancestries of racial and eugenic systems of violence in the mental health sector

Paper

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Focus: Guidance
Keywords: Critical mental health, postcolonial theory, social justice, ethics, violence

Introduction:

There is a long history of contributions to the goals of social justice in mental health. As we engage with this complex area of the human condition, we must consider all forms of injustice and advance with the utmost of care so as to not reproduce violence in our theoretical formulations, practices and research. In the recent past, inequities in mental health services (that fail to serve minorities and marginalized groups) have been addressed as an issue with *"cultural competence"* or a need for more *"evidence"* often ignoring the contributions that have highlighted the methodological, epistemological, historical, and political issues that perceive the violence within these solutions and the genealogy of their basis in modernizing, Eurocentric, eugenic, racial thinking. These contemporary solutions leave the systems intact that seek to taxonomize, finalize and encapsulate people into a general type, see them through the lens of difference, develop disciplines, professions and expertise on the *"Other"* who is always represented in terms of lack. Some of the most violent forms of injustice are often misrecognized or unrecognized in our current mental health system even though the system itself is the current perpetrator of this violence. Harmful and forced treatments, forced confinement and the disproportionate deportation of racialized minorities who are diagnosed as mentally ill continue to be regular practices of the mental health system in collaboration with the criminal justice, and immigration systems (Joseph, 2013). These systems have inherited a common ancestry that must be considered within the context and outcomes of colonization in order to be appreciated for their capacity for violence.

Research on race and mental illness appears to invoke a rationale for why *"immigrants"* and racialized minorities are *"more prone"* to mental illness and experience more discrimination in terms of an ability to access mental health service. This occurs do to a tendency in mental health research to reconstitute representations of racialized minorities as distinct from the core of society. This analysis pays insufficient attention to the broader social, historical and political context of the development of these systems for colonial and imperial projects and the production of difference. A critique of the process of diagnosis, the forms of treatment applied, and the historical and political contexts of these issues remain excluded. This limitation also creates an illusory void which allows for society to ignore the violence that the mental health system itself perpetrates while advancing the reputation, professional expertise of disciplines, and laws that claim a project of mental *"health"* and wellbeing.

Researchers have pointed out that there is a disproportionate representation of non-Western, racialized people within forensic psychiatric systems and have suggested that racism exists both within the diagnostic process and with forensic psychiatric services (McKenzie, 2004; Fernando, Ndegwa, & Wilson, 1998). Canada›s immigration laws have produced and reinforced an atrocious legacy of social prejudice against persons deemed to have mental disabilities revealed through an analysis of the Canadian Immigration Act of 1886, 1906 and the Canada House of Commons debates of 1910 (Chadha, 2008). The legislation and debates advocated for the deportation of immigrants with mental disabilities (Chadha, 2008). As a Canadian crime study of immigration status appeals cases revealed, racialized immigrants were deported more often than immigrants from Anglo-European countries (Chan, 2005).

Colonization and colonial violence

Colonization refers to a historically established and enduring process whereby colonies are built in one territory by people from another territory and the dominating territory changes the social structure, government, and economics of the colonized territory. This colonization usually occurred to increase profits or economic gains through exploitation, to expand power through land appropriation or to expand religious domains (Césaire & Pinkham, 2007; Fanon, 1965; Gandhi, 1998; Loomba, 1998; Said, c1978; Young, 2001). Colonial violence has been described as having four levels including, brutal physical violence against another person, control & containment of violence inflicted upon others, suicide, and the violence that occurs when writing about other people (Kunreuther, 2006; Achebe & Irele, c2009). This also includes the violence of colonial classifications (Kunreuther, 2006; Achebe & Irele, c2009). The sovereign power of the colonial state was always predicated on the violent subjugation of indigenous people, slaves, or indentured laborers, as violence was integral to colonialism (Rand, 2006).

Histories of madness

To begin our discussion it is important to direct our attention to the historical development of the concept of mental illness, the development of mental health systems, laws, categories, and theories. As Roy Porter describes, *"Madness may be as old as humankind. Archaeologists have unearthed skulls dated back to at least*

5000 B.C. which have been trephined or trepanned. The subject was thought to be possessed by devils which the holes would allow to escape" (Porter, 2002, p. 10). In the Old Testament, madness was depicted in stories of possession by devils *"usually as a fate or punishment"* (Porter, 2002, p. 10). Nebuchadnezzar was punished by the *"Lord reducing him to bestial madness"* (Porter, 2002, p. 10). As these brief examples highlight, historical concepts of madness included religious, spiritual and social explanations. These explanations also point to the understanding that everyone had the potential for madness, and that madness was not always understood as an affliction residing in particular individuals with separate biological circumstances.

Elizabeth Packard, reform from behind the walls

Elizabeth Parsons Ware Packard (born 1816) was kidnapped with the aid of her husband and imprisoned for three years after she *"defended some religious opinions which conflicted with the Creed of the Presbyterian Church"* (Packard, E., Olsen, S. & Shedd, T., 1994, p.59). Packard drafted what is known as the Packard laws which included bills for reform in three areas, the first area of *"personal liberty"*, demanded a *"jury trial for commitment of any person alleged to be insane"* (Carlisle, L, 2004, p.3.). The second area asked for *"postal rights"* for patients to send and receive mail to protect against false commitment and *"deter mistreatment"* (Carlisle, L, 2004, p.3.). The third area demanded the establishment of *"visiting committees"* to *"oversea conditions of asylums, hear patient's complaints, and monitor the decisions of the superintendent and trustee"* (Carlisle, L, 2004, p.3). Packard's contributions highlight for us how the voices of those deemed mad, have the unique capacity to challenge the power of professional authority, the process of categorization that separate individuals into distinct types and expose the injustice that targets specific groups. From the Packard story we also begin to see the legal and discursive delineation between the mad (those who deserve rights and protections), the bad (those criminally responsible to an unacceptable act), and the position of psychiatry as a professional authority on these matters.

In Madness and Civilization, Foucault outlines the historical and cultural developments that constructed mad people as a threat to the civilized and their need to be confined for moral and economic reasons (Foucault, 1965). According to Foucault's historical analysis, the benevolent aims of moral treatment disguise the moral oppression that seeks to ensure the separation and confinement of undesirables and impose moral changes aimed at restructuring a person's *"rationality"* and *"reason"* (Foucault, 1965). Foucault tracks the development from the renaissance when mad people were appreciated for their knowledge and wisdom to the enlightenment era when madness was equated with unreason (Foucault, 1965). As the treatment of the mad became entirely supervised and authorized by psychiatry within institutions, rational, reasonable society became separate from the mad (Foucault, 1965).

Focal Sepsis, psychosurgery and the rise of biomedical psychiatry

In the late 1800s and early 1900s the concept of mental disorder as having biological roots was also under significant development. Andrew Scull's book, Madhouse: A Tragic Tale of Megalomania and Modern Medicine, is a detailed historical account of Dr. Henry Cotton's use of extreme psychosurgeries to treat mad people during his tenure at Trenton State Hospital in New Jersey from 1907 until 1930 (Scull, 2005). Dr. Henry Cotton was a superintendent at Trenton whose belief in a bacterial cause of mental illness, lead to a tragic period of inhumane *"treatments"* to remove focal sepsis or sites of infection by extracting teeth, tonsils, the cervices of women and by performing partial or complete colectomies (Scull, 2005). Scull notes that the lesson we should take from Dr. Cotton's story is that this was not an anomalous aberration or momentary lapse with no connections to psychiatry today. We need to be able to question the ethical conditions of practice and research, and require external input including the voices of patients. From the above few and brief historical references, we can begin to see the development of concepts of madness from religious, spiritual or social, from a time when no special provisions were made for the mad, to a period of increasing emphasis on biological *"causes"* of madness. We also begin to see the development of the asylum, differentiated laws for those deemed mad, the use of violence, and the dominance of biomedical psychiatry as the sole authority on madness.

Contemporary critical perspectives on psychiatry

The biomedical model of psychiatry can be said to adhere to a positivistic epistemological approach to knowledge. Modern Western Philosophy credits philosophers of the enlightenment era in Europe during the Middle Ages such as Descartes, and Immanuel Kant for recognizing (or revitalizing) the value of skepticism and breaking free from Christian theology in order to engage with newly emerging scientific ideas that favored rational thought to dogmatism (Foucault, 1984; Williams, 2001). The ideas that stemmed from these contributors valued reason, empiricism, science, universalism, notions of progress, and a belief of a single uniform reality that could be observed.

David Ingleby's book Critical Psychiatry: The politics of mental health criticizes the adherence to positivistic epistemological stances within the profession of psychiatry and questions the notion of objectivity that has been critiqued as early as Durkheim in 1895. As Ingleby notes, *"Positivism assumes…that observations can be made objectively-that measures can be defined operationally, and applied in a precise, replicable fashion; and…that theories can be constructed on the same causal, deterministic basis as in the natural sciences"* (Ingleby, 1981, p.28). Ingleby recognized the possibility in principle of stating exactly the criteria for applying physical concepts but also recognized the impossibility *"to do so for concepts describing human activities and states of mind"* (Ingleby, 1981, p.32). As he describes, the descriptions of human activities and states of mind are always subject

to interpretation, *"not in the sense that there are no criteria, but that the criteria are unstated ones, lying in the culture itself"* (Ingleby, 1981, p.32). Ingleby's analysis offers both an epistemological and methodological critique of biomedical psychiatry but his analysis of the *"social and political"* is deeply imbedded in the Eurocentric view of historical development. Specifically, he looks to theorists and research from America, Britain, France and Italy. Ingleby's social and political concerns engage with issues of democracy and advanced capitalism.

Eurocentrism assumes that there are two time periods in history, that up until the renaissance (pre-capitalist society) and the growth of capitalism from the renaissance onward. Eurocentrism also assumes *"that imitation of the Western model by all peoples is the only solution to the challenges of our time"* (Amin, 1989). This imitation often alludes to a specific construction of history in Europe from Greek antiquity through the middle ages to the *"enlightenment"*. Enlightenment ideas focus on the search for universal truths through the use of reason. Any pre-capitalist, pre-modern, pre-enlightenment countries, periods, or ideas are seen as naïve or archaic. Although Ingleby's analysis advocates for a consideration of culturally accepted *"truths"* and their alignment with capitalism and democracy in Western nations, there are no first person perspectives or discussion of particular political projects including specific attention to colonization or an analysis pertaining to the production of difference and race.

Suman Fernando's book, Mental Health, race and culture (2010) challenges modern Western approaches to mental health with his analysis of race, culture, ethnicity and identity in contemporary mental health systems. Fernando provides a thorough analysis of racism within Western psychiatry and offers suggestions for alternative approaches for understanding mental health (with examples from spiritual and Asian understandings) and alternatives for treatments including Yoga, Herbal remedies, Acupuncture, and Meditation (Fernando, 2010). Fernando describes the tradition of Western approaches as *"the culture of psychiatry"* and suggests that a multi-cultural perspective that allows for a pluralistic view of mental health will also provide the basis for universal understandings (Fernando, 2010, p. 175). Although Fernando identifies that imperial and colonial projects are linked to the rise of ideas of difference and race and that these become institutionalized in mental health services, he does not provide an analysis of the historical development of the mechanisms that produce hegemonic disciplines, professions, discourses that dominate mental health systems and juridical structures in relation to colonization and imperialism. This analysis would allow for recognition of the social relations that position Western biomedical perspectives as superior to Others and would problematize the processes of taxonomization and of categorization of difference for civilizing and moralizing projects. For Fernando, if we add multiple perspectives from multiple understanding across cultures, we can reduce the amount of racism within mental health diagnosis and treatment and allow for a spectrum of services and understandings. With this suggestion, we ignore the violence within the processes of taxonomizing *"cultural practices"* and the (re)packaging of these ideas for offering mental health services and treatment. The appropriation, reduction and colonial violence within such a suggestion would go unnoticed without a thorough analysis of the historical, eugenic ideas, and colonial projects whereby these essentialized *"alternative cultural approaches"* could be perceived as dangerous when wielded to *"change"* those identified as different.

Without an analysis that examines of the current technologies and practices that persist from a lack of attention to the history of colonization, anti-oppressive approaches that advocate for racialized minority groups within mental health systems will continue to do so through the advancement of discourse that highlights difference as a requirement for distinctions in treatment, therapy, or access to mental health services. Upon this premise, an anti-racist mental health service cannot exist. In order to further our analysis we must consider the specific connections between colonization and the eugenic and racial thinking within the development of our concepts of mental illness, madness, and psychiatry.

Connections between colonization, eugenic, racial thinking, the regulation of immigrants and the development of mental health systems and policies:

Ian Dowbiggin's book Keeping America Sane: Psychiatry and Eugenics in the United States and Canada, 1880-1940, provides a detailed account of the history of Eugenic thinking and policy development within psychiatric and legal domains in Canada and the United States (1997). Eugenics is a term coined by a cousin of Charles Darwin, Francis Galton in 1883. Galton defined Eugenics as *"the study of the agencies under social control that may improve or impair the racial qualities of future generations"* (Francis Galton, Inquiries into Human Faculty and Its Development, 1907, p.17 cited in Dowbiggin, 1997). Eugenicists argue that *"the sterilization and institutionalization of the mentally disabled as well as laws restricting immigration and marriage would improve public health"* (Dowbiggin, 1997, p. vi). The first Asylum in Canada was opened in St. John, New Brunswick, in 1836, the Toronto Asylum was opened in 1850 (Dowbiggin, 1997). The exposure of deplorable conditions marked the beginning of the end of psychiatrist run state asylums, as they became more accountable to state politicians (Dowbiggin, 1997).

After the asylums were under provincial authority, psychiatrists saw the benefit of working bureaucratically with Provincial administrators to influence policies within the provincial mental health system. Charles Kirk Clarke (after which the former Clarke Institute of Psychiatry in Toronto is named, now a site of the Centre for Addiction and Mental Health) *"was arguably the most famous psychiatrist Canada has ever produced"* (Dowbiggin, 1997, p. 17). C.K. Clarke *"struggled mightily"* to *"ensure that mentally and physically handicapped immigrants could not enter the country and take advantage of Canada's charitable institutions"* (Dowbiggin, 1997, p.133). In 1906, *"the Canadian government had made deportations legal for the first time. Immigrants,*

who within two years of their arrival in Canada ended up in a publicly funded charitable institution, were eligible for deportation" (Dowbiggin, 1997, p.150). In 1910, the law was amended from 2 years to 5 years with the help of Clarke's advocacy (Dowbiggin, 1997). To this day, immigrants are ineligible for social assistance (including disability support program) income for the duration of their sponsorship which can be up to 10 years. The story of C.K. Clarke and the influence of eugenic and racial thinking in Canada demonstrates the authority of psychiatry to influence criminal law, immigration law, and social policy. The rationale for these policies that continue to exist include the belief that newcomers carry some sort of *"defectiveness"* that is both a burden to society and a threat to the purity of the *"Canadian"* race.

Canada's early asylum and colonial administrators were often one in the same and communicated with other asylum and colonial administrators both at home and abroad in the United States, the United Kingdom, and other parts of Western Europe regularly in the effort to share information on how to run asylums efficiently as part of world-wide colonial projects (Roman, Brown, Noble, Wainer, & Young, 2009). Also, *"the colonization and segregation of First Nations people in residential schools involved judges, doctors, and psychiatrists confining those deemed as medically or psychiatrically 'unfit' – whether First Nations or not– to asylums and hospitals"* (Roman, Brown, Noble, Wainer, & Young, 2009, p.18).

In Jonathan Metzl's book The Protest Psychosis (2009), a detailed analysis is provided on the changes in criteria for schizophrenia from docility to rage beginning in the 1960s and the psychiatric and medical targeting of African Americans. Metzel describes early diagnostic categories for African Americans including Drapetomania (the *"insanity"* of black slaves running away from white masters) and described a condition called Dysaesthesia Aethiopis, a form of madness manifest by *"rascality"* and *"disrespect for the master's property"* that was believed to be *"cured"* by extensive *"whipping, hard labor, and, in extreme cases, amputation of the toes"* (Metzl, 2009, p.30).

In the 1960s, research articles in psychiatric journals began asserting that schizophrenia was a condition that afflicted *"negro men"* and that black forms of the illness included the schizophrenia of civil rights protests, *"particularly those organized by Black Power, Black Panthers, Nation of Islam, or other activist groups"* (Metzl, 2009, p. xiii). Rage became a diagnostic feature. The title of the book comes from a 1968 article from the Archives of General Psychiatry that describes schizophrenia as a *"'protest psychosis"* that made black men develop *"'hostile and aggressive feelings' and 'delusional anti-whiteness' after listening to the words of Malcolm X, and joining the Black Muslims (Metzl, 2009, p.xiv). Pharmaceutical companies advertised anti-psychotic medications for the control of this "primitive"* and *"aggressive"* behavior (Metzl, 2009). Although Metzl criticizes the racism within psychiatry he denies that schizophrenia is a socially constituted disease (Metzl, 2009, p. xvi-xvii). Metzl fails to recognize the violence within the diagnostic processes and treatments of biomedical psychiatry or their relation to the production of difference based on racial, eugenic thinking and colonial projects.

Orientalism and violence:

Edward Said offers analyses that speak to the discursive violence and development of hegemonic academic and professional disciplines forged on a complete knowledge of the Other, predicated on the violence of colonization and highlight the discursive, literary and cultural practices aimed at regulating and civilizing the uncivilized Other. Said demonstrated in Orientalism how orientalist discourse justified and advanced colonial rule through Western Academic knowledge and a will-to-power to govern the Orient (Young, 2001). According to Said, there were a number of productive outcomes that have forged themselves into the practices of academic disciplines and claimed objectivity during colonial projects. Individuals in the orient were subordinated into a general type and posed through consistent binaries that set Europe apart from *"the orient"* geographically, racially, and religiously (Said, c1978). The *"Orient"* becomes static and unchanging, and authors on the subject draw clear distinctions between themselves and the orient (Said, c1978). The orientalist also produces an overarching sense of contempt for the Other, and becomes the expert who knows the oriental better that the oriental can know her/his self (Said, c1978). From Said, we see how the creation of general taxonomies, the production of difference, the rise of expertise and professional hegemony developed during colonization and was inextricably linked with racial thinking, hierarchy, dominance, geopolitics and knowing the Other better than they know themselves. These colonial products continue to exist within professions such as biomedical psychiatry and social work and must be acknowledged within the violent historical and political context from which they developed in order to appreciate their capacity for violence in the present.

Resisting erasure and essentializing representation in Western scholarship:

In mental health scholarship we often rely on broad sweeping, essentializing representations such as psychiatric-consumer-survivors, mad people, people with mental health issues, etc. and a Eurocentric historiography that confines our analysis. Our inattention to the colonial products of difference based on eugenic and racial categories allows for certain kinds of colonial violence to persist. When difference, distance, Eurocentrism and hierarchy become the basis for critique, our unfortunate outcome is a continuation of these violent colonial products, and a limitation in our options for transformation.

Emmanuel Levinas (holocaust survivor and philosopher) studied under Marin Heidegger at the University of Freiberg in 1928. Levinas critiques Heidegger's rationalization and justification for Nazism revealing how *"'ethical' categories can too easily be invoked as a moral justification for atrocities"* (Murray, 2003, p.27). However, for Levinas, ethics can be salvaged if we begin from the encounter with the Other as *"the immediate source of ethical obligation"* (Murray, 2003). For Levinas, the Western world has been too concerned with the

self, the *"nature"* of being and totalizing *"the world by enclosing everything within a system of knowledge"* (Murray, 2003). A metaphysical perspective that begins from the encounter allows for a consideration of that which exists outside of representation or *"the infinite [which] names the Other's ungraspable or incomprehensible character"* (From Levinas Totality and Infinity cited in Murray, 2003, p.30). Levinas recognized the violence within any attempt to know the Other *"as any description or categorization of another person is always a reduction of their full otherness"* (Murray, 2003, p.30). For Levinas the encounter with the Other is an experience of ethical obligation, not one of knowing. Therefore ethics, which begins from the relationship with the Other, is not a derivative from ontology. The relationship with the infinite Other, based on ethical obligation determines being and knowing (Murray, 2003). A respect for any Other (outside the self) and the infinite precludes the ability for the production of difference and the rationalization of violence. From a Levinasian approach to ethics, we are given a hopeful continuity that resists the fragmentation of difference and the separation of issues of justice from one another. From the Infinite, and by beginning with relationship, we have the possibility of hope, the prospect of transformation, the kind that does not rationalize any form of violence.

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Learning objectives

1. A review of literature and research on the connections between colonization, eugenic thinking, racial ideas, the regulation of immigrants and the development of mental health systems and policies.
2. To expand the modern, positivistic, biomedical psychiatric notions of violence and mental health to allow for recognition of the historical, political and colonial violence produced by the mental health system in addition to the violence it attempts to reduce or prevent through the use of harmful and forced treatments, confinement, deportation and the deployment of dehumanizing discourse based on racial and eugenic ideas.

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Protecting client and employee safety through implementation of the Collaborative Recovery Model in mental health

Workshop

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Focus: Practice
Keywords: Workplace violence, aggression, abuse, mental health, violence prevention and control, risk factors

Introduction

Workplace violence-related injuries are becoming increasingly prevalent in the health and community care sector, particularly in mental health facilities. Traditional approaches to managing workplace violence in mental health have been focused on methods to contain or reduce the impact of the violence/aggressive act, rather than to seek out the root cause for the event and apply the appropriate controls. Controlling violence and aggression actually involves integrating safety into clinical practice and patient care.

In tertiary mental health facilities, a comprehensive systemic approach is required to effectively prevent aggression and promote client and staff safety. Instrumental to the approach is the collaborative recovery philosophy that emphasizes recovery as a subjective and personal experience and the means to recovery as a collaborative effort between mental health care providers and their clients. A critical outcome of supporting a strong therapeutic alliance and client collaboration in recovery is a reduction in violent incidents as research has found that the weaker the therapeutic alliance, the higher the risk of the client exhibiting physical attacks or fear-inducing behavior, especially during their first week of hospitalization.

To promote quality of client care and staff and client safety in mental health settings, Ontario Shores Mental Health Sciences Centre collaborated with Public Services Health and Safety Association and developed the comprehensive Clinical Assessment (CA) tool. The tool consists of a questionnaire for frontline caregivers and a questionnaire for management staff and includes four main assessment areas: 1) assessment of a client's potential for violence/aggression on admission; 2) assessment of clinical practice infrastructure to support collaborative recovery (including reduction of seclusion and restraints); 3) staff development; and 4) clinical practice caregiver assessment – specifically looking at the therapeutic alliance and relationship between caregiver and client. The CA tool provides a snapshot of the current violence prevention activities and helps to measure and monitor effects of an organizational collaborative recovery model. The CA tool was used to test the effects of the Managing Relationships Through an Interprofessional Collaborative Recovery Model (MRICRM) at Ontario Shores.

The objectives of the initiative include advancing the understanding of the importance of an integrated approach to managing relationships in a mental health setting and developing a validated clinical assessment tool that mental health facilities can use as a baseline assessment and/or as an evaluative tool. This session will examine how one mental health organization planned, implemented, evaluates and sustains an interprofessional care model with the use of the clinical assessment tool.

The Public Services Health and Safety Association (PSHSA) is a not-for-profit agency that serves Ontario's public service sector through prevention training, risk assessment and safety consulting services, as well as a wide range of training and information products. PSHSA assists organizations in the community and healthcare, municipal, education, and government sectors in achieving safer and healthier work environments.

Ontario Shores Mental Health Sciences Centre, a 329-bed tertiary-care mental health centre in Ontario, Canada, has begun the organizational change process of implementing a collaborative-recovery philosophy to enhance client care and foster a safe environment for employees and clients. Their new model of care, the Therapeutic Relationship Model , sets the stage for transformation from a traditional service delivery model in tertiary mental health, to an inter-professional, strengths-based model that relies on all team members working within their full scope of practice, while integrating collaborative team-based approaches to care. The key domains of the model are the Human Contextual Factors, the Six Core Strategies (NASMHPD, 2008) and Therapeutic Milieu and the Collaborative Recovery Model.

The Human Contextual factors take into account – trauma exposure, personal insight, knowledge, immediate stressors, communication strategies, transference (patient), counter-transference (staff), mental and physical health, assumptions, values and judgements, interpersonal functioning, experiences and relational history. Assessment for and awareness of these factors and impact on behaviours is key for clinicians when planning and delivering care.

The Six Core Strategies to reduce the use of restraint and seclusion include – Leadership toward Organizational Change, Use of Prevention/Proactive Tools, Workforce Development, Debriefing Techniques, Patient/Client Roles in an Inpatient Setting, and Use of Data to Inform Practice. The Six Core Strategies are evidenced-based and provide guidance for mental health settings to transition towards minimization of seclusion and restraints and promotion of trauma-informed care.

The last domain incorporates the two guiding principles and four components of the Collaborative Recovery Model (Oades et al, 2005). The foundational principles of the Collaborative Recovery Model (CRM) support a preventative and therapeutic approach to mental health care, emphasizing recovery as a subjective and personal experience, which requires extensive collaboration between the client and mental health care provider (Oades et al., 2005). The CRM creates a recovery-oriented approach to mental health care with specific knowledge, skills and attitudes for practitioners.

Findings

To complement the introduction of the Therapeutic Relationship Model the Clinical Assessment tool was administered as a pilot at Ontario Shores. Results of the pilot study showed statistically significant positive changes, including a reduction in the rates of code white incidences and mechanical restraint incidents. The CA Tool also indicated a variance between the perception of staff and the perceptions of the clinical leadership team in areas like adequate program structure, considerations for environmental factors and leadership to support violence prevention. Further use of the tool is underway to provide a mechanism for obtaining confidential feedback and a structure for addressing identified needs and gaps in the areas identified.

Conclusion and/or Discussion

The Clinical Assessment tool will foster development of a system of care that integrates patient and employee safety and reduces workplace violence in the mental health setting. The outputs from the use of the CA Tool and the ability to focus collaboratively at the unit and manager level have enabled open dialogue and problem solving.

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Learning objectives

1. By the end of this 1 -hour interactive workshop, participants will be able to recognize the important link between the recovery philosophy and a reduction in aggressive and/or violent incidents.
2. By the end of this 1 -hour interactive workshop, participants will be able to utilize the Clinical Assessment tool as a strategy to prevent and manage aggression and/or violence as a therapeutic intervention.

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Systemic roots of workplace violence: How funding, regulations, administration and quality assurance create toxic cultures

Workshop

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Focus: Organisational
Keywords: Workplace incivility, workplace violence, healthcare, systemic integration, translational services, administrative bullying

The administration of healthcare services is often named as a critical feature of any effort to reduce WPV and WPI. (LeBel 2011). Other features often mentioned are staff training and staff competencies, and the implementation of therapeutic and/or safety interventions. Workplace Incivility (WPI) and Workplace Violence (WPV) are descriptive models that describe violence and incivility as behaviours occurring within workplace relationships. (Andersson & Pearson 1999, Sims & Keon, 1999, Bowie, 2011)
These workplace relationships are formed in the context of the work that must be done. Broadly stated, human services *"uniquely approaches the objective of meeting human needs through an interdisciplinary knowledge base, focusing on prevention as well as remediation of problems, and maintaining a commitment to improving the overall quality of life of service populations. The Human Services profession is one which promotes improved service delivery systems by addressing not only the quality of direct services, but also by seeking to improve accessibility, accountability, and coordination among professionals and agencies in service delivery."* (National Organization for Human Services, 2012)

The mission of healthcare organizations, as a specific subset of human services, is to provide the highest quality of health care possible to patients within the constraints of the available resources. This mission is either supported or impeded by:

- The allocation of resources through various governmental, private insurance and other payment options
- Regulations developed by funding and/or oversight agents, including accreditation bodies
- The administration of healthcare services
- The measurement of what constitutes quality outcomes
- The skills training and competence of all staff in the provision of healthcare
- The methods used to respond to threats to the emotional, psychological, and physical safety of all people within the healthcare sector
- The actual implementation of therapeutic or safety interventions

In this article, the authors will focus on one aspect of the model, that of funding, quality assurance, and regulatory bodies, and how these three are addressed by administrative action and/or inaction within organizations.

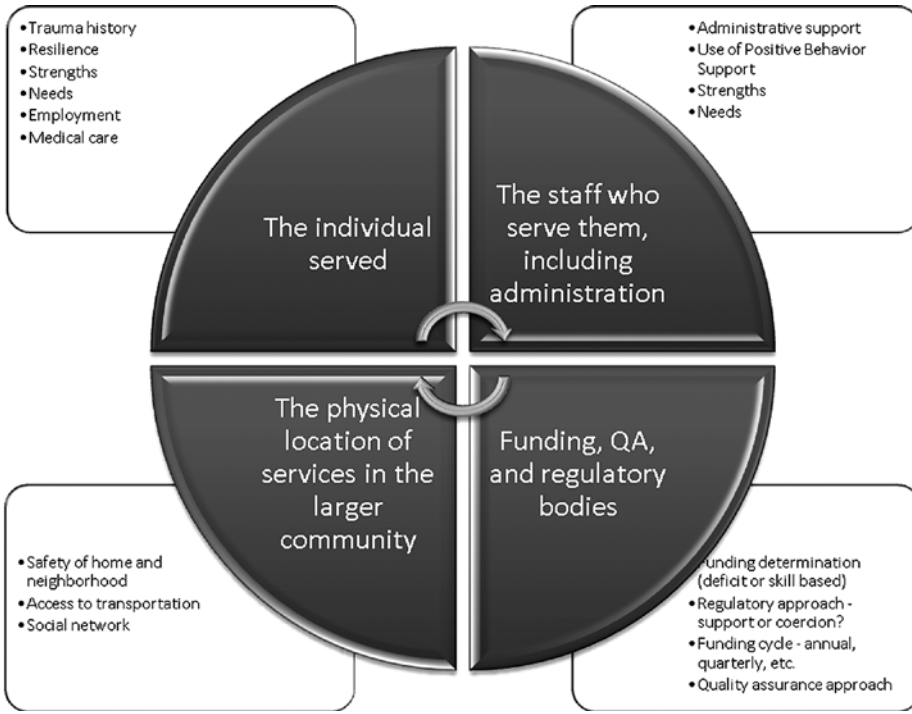
Peter Armstrong (2011) describes what he calls *"budgetary bullying"* in an article from *"Critical Perspectives in Accounting"*. The ways in which resources are allocated, decisions by insurance companies on who, when, and how to treat people can either contribute to WPI and WPV or they can contribute to civility and safety. The stresses on clients, families, clinicians and administrators relative to the allocation of resources to accomplish treatment goals has increased significantly under the American style of payment for health services. (Alexander et al, 2006)

The terminology used in describing services vary not only from country to country but also within service sectors in individual countries. The focus in all these models is the empowerment of service users to make decisions for their own lives, using a strengths based model. Service providers are seen as supportive agents of change instead of directive agents of change. (Bowen, 1992). However, the funding for human services, without exception, is based not on the strengths of individuals, but rather on their deficits, areas of needs, targeted behaviors, etc.

This dichotomy results in an approach to services that is theoretically at odds with implementation strategies, resulting in conflict within organizations between the people who are responsible to implement services, and the people whose responsibility it is to fund those services, and measure compliance with outcomes expected by the funding agent. When budgetary controls are put in place in order to maximize service stability, the end result is often conflict between *"program staff"* and *"administrative staff."*

In many American states, licensing agencies whose staff have little, if any, clinical experience are requiring clinicians to use interventions and programmatic approaches that are benign at best and neglectful or abusive at worst. Such actions may be examples of budgetary bullying. WPI and WPV can and do occur outside of interpersonal relationship, and the authors postulate that these are *"setting events"* (LaVigna & Willis, 1992) which exacerbate behavioral responses to stress, resulting in WPI and WPV.

Figure 1



Again, the conflict between staff whose responsibility it is to measure program outcomes and the staff charged with implementing programs is created by the disconnect between funding areas of skill deficit and at the same time implementing program structures based on individual strengths. Settings serving individuals who display significant levels of behavioral concerns are especially susceptible to this disconnect in service design, as the desire to *"control behavior for safety reasons"* is at odds with the desire to *"continually move away from coercion."*

Because regulatory bodies are often also funding agents, the coercive nature of combining regulation and funding results in a culture in which WPI can easily take root. The purpose of regulation is to manage risk and achieve desirable social outcomes. Since the 1980's, America has embarked on regulatory reform, but after 30 years of work, risk has increased and regulations continue to be promulgated in ever larger volumes. (Hastings, 2012) The recent data from the Bureau of Labor Statistics shows that workplace violence was reduced in all service sectors except human services. (Janocha and Smith, 2010)

Managing risk and improving efficiency and safety is one way to conceptualize the efforts to reduce and ultimately eliminate the use of restraint and seclusion in mental health services specifically, and other human services by extension, have resulted in conflict and WPI at the very least in America and perhaps in other countries. Staff perceptions initially indicate resistance to restraint reduction efforts, and this resistance is at times so strong that restraint reduction efforts fail. The WPI between staff is seen in blogs on the website *"thetruthaboutpronerestraint.com"* and in the discussion about the ineffectiveness of Positive Behavior Support and the lack of consequences for specific client behavior.

Compliance to safety protocols to manage risk and to standards of performance to meet regulatory expectation is the overall task of what is known as Quality Assurance, Total Quality Improvement, and other terms. In an effort to do so, the process of debriefing attempts to correlate employee actions and/or inactions with outcomes relative to service users. Quality Assurance staff often are perceived as those persons with no real life experience telling us what we did wrong." In several American states, any allegation of misapplication of restraint results in suspension without pay until the investigation is completed, which often takes months. This approach again sows the seeds for WPI and WPV.

Bowie (2010) encourages that as we look at the issues of WPI and WPV we do more than just look at the *"bad apple,"* we investigate the health of the barrel as well. A literature review on the topic of systemic influences on WPV and WPI (Bowen et al, 2011, demonstrates that the toxicity present in organizations experiencing high

rates of relational violence or physical aggression in the form of physical and/or mechanical restraint imposed as a result of perceived aggression has a source, and the literature indicates that the source is within the culture of the organization.

This dichotomy between personal accountability and the management of risk in a larger human service setting creates situations of ambivalence, fear, and a hesitation to move forward in stressful situations. As long as the focus is on compliance with outcome expectations set by regulatory bodies who also fund services, WPI will the the natural response in stressful situations. Blaming other people for perceived shortfalls in behaviour is a common human response to stress.

In this interactive session, the presenters will use a tool to facilitate measurement and discussion of the level of WPI and/or WPV in the areas of:

- budgeting of resources
- promulgation of regulations and how those regulations are enforced
- administrative structures and schema
- quality assurance protocols
- skills training methodologies
- implementation of interventions guided by duly licensed/certified/educated clinicians.

The presenters will discuss translational models of care that transcend typical professional disciplines in human services and have been demonstrated over time to provide environments where people can live, learn, work and play with an increased feeling of safety. This stability has resulted in a lowering of workplace violence and more importantly an increase in the safety of individuals served and the staff who serve them.

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Learning objectives

1. Measure the relative toxicity of different parts of the system in which healthcare services are provided and received.
2. Develop a safety plan to counteract the systemic influences described above.

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The mediating effect of workplace violence on depression in the private and public health sectors

Poster

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Focus: Research

Abstract

Background and objective

Based on anecdotal experience it seems that differences in the impact of workplace violence exist between private and public healthcare settings. Thus, the objective of this study was to investigate differences in the associations of depression with verbal workplace violence in the private and public sectors in Seoul City.

Methods

One hundred and eighty six workers from 10 private hospitals and public healthcare centers in Seoul City were selected. Professional nurses were included but shift workers excluded. The self-administered questionnaire comprising job stress, depression, emotional labor, work-life imbalance and violence at work was administered. Logistic regression with depression as the dependent variable and the effect modification of working sector toward the association of violence to depression was conducted by measuring the rate ratio with 95% confidence intervals.

Results

The depression group comprised 12.1% of workers from the public health and 13.9% from the private health sector. In case of private health group, experiences of verbal violence showed significant association on depression (OR=11.09, 95%, CI 2.27-54.07). The rate ratio of verbal violence on depression in private health group compared to the public health group was statistically 9 times higher (RR=9.81, 95%CI=1.19-80.29).

Conclusions

The experience of verbal violence at work could be a risk factor for depression in health care workers. Moreover, in cases of private hospitals, the effects of verbal violence on depression seem to be reinforced. Based on these results it is inferred that the working conditions of private hospitals should improved in order to promote mental health and prevent verbal violence at work.

Learning objectives

1. To demonstrate the mediating effect of verbal violence on depression rates in health care workers.
2. To demonstrate difference in the ratios of verbal violence as a mediator of depression between the private and public sectors, and to suggest a path for improvement.

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Working towards bully-free workplaces: An innovative approach addressing workplace Violence in Nova Scotia Health Care

Workshop

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Focus: Education and Training
Keywords: Culture, perceived injustice, bully-free workplaces, restorative practices, union

Background

The Nova Scotia Government and General Employees (NSGEU) believes in the responsibility of the union to address the problem of workplace bullying as a form of violence. The International Labour Organization (ILO, 1999) report on workplace violence emphasized that physical and emotional violence is one of the most serious problems facing the workplace in the new millennium [1]. This definition of workplace violence includes bullying as *"any incident in which a person is abused, threatened, or assaulted in circumstances relating to their work. These behaviours would originate from 'customers', or co-workers at any level of the organization. This definition would include all forms or harassment, bullying, intimidation, physical threats, assaults, robbery, and other intrusive behaviours [2]."* This is underscored by Nova Scotia's Occupational Health and Safety Act [3] which states, *"Every employer has a duty to provide a safe and healthy workplace."*

The NSGEU, Nova Scotia's largest union, developed and implemented a Bully-Free Workplaces Program. This uniquely member driven program launched its Bully Free Workplace initiative in September 2010 with the objective to deliver a two hour awareness seminar or a six hour interactive workshop. Union membership of over 30,000 includes approximately 12,000 health care workers. Health care representation in development and delivery of the program included public health nurses, a community based rehabilitation counsellor and social workers. A province wide pilot, integrating quantitative and qualitative evaluation data confirmed the overwhelming positive acceptance of the program by both employees and their employers. Participant feedback, notably from within health care settings, quickly determined the need to advance the program beyond education in defining and naming the problem, to introducing intervention strategies.

In addition to eliminating bullying behaviors through policy, appropriate investigation and sanction, is the emerging field of restorative practices. This offers a common thread uniting theory, research and practice in seemingly disparate fields, such as nursing, education, counselling, criminal justice, social work and organizational management. A restorative practice framework offers a range of approaches that give those most affected by conflict the tools and principles needed to resolve problems and build relationships.

To date over 7000 participant evaluations demonstrate that intervention must include appropriate identification of the situation, address both workplace policy and culture, and move us beyond the rigidity and unenforceability of 'zero tolerance'. Participants have an introduction to using restorative practices in creating a healthy workplace culture. In this successful undertaking the scope of the program continues to evolve to examine policy, remediation and restoration. With the stretching of current resources in health care and no new monies this is an approach that employers can adopt, utilize and transfer into all arenas of work.

Method

The facilitator led workshops deliver motivating, participant focused sessions employing PowerPoint, flip charts and group activities and written evaluation is strongly encouraged. The two hour awareness sessions explores the effects of bullying on the individual, co-workers, family and the workplace. The six-hour interactive workshop explores issues in greater depth using a variety of adult learning strategies to engage participants and help in understanding problems and solutions to workplace bullying. Topics addressed include defining workplace bullying, as well as bullying behaviours and characteristics, who gets targeted, incivility, common behaviours of a bully, organizational effects and recognizing the whole person health impact. Lastly the facilitator moves to address situations by offering tips and tools. This allows introduction of restorative practices which looks at repairing harm as an alternative to traditional disciplinary and often punitive approaches.

The session objective has participants be provided the opportunity to experience how a peer to peer approach is an effective and beneficial method to address workplace bullying as well as offer a solution focused format. Activities incorporated into the session provide the opportunity to self-reflect and respond to their own work life experience whether a target, bystander or person who engages in bullying behaviour.

This paper focuses on a comparison between two provincial health districts in Nova Scotia where the Working Toward Bully-Free Workplaces Workshops were implemented, between May 2011 and May 2012.

Nova Scotia comprises nine health districts, the largest being the Capital District Health Authority, with the NSGEU representing approximately 12,000 members who work within health care. In addition our workshops have included members of the Nova Scotia Nurses Union (NSNU) and the College of Licensed Practical Nurses (LPN's). The following table highlights the range of health care settings where the program has been delivered. Discussion will focus on these two settings.

Table 1. Working Toward Bully-Free Workplaces Program Delivery With in Nova Scotia Health Care

South Shore District Health Authority	Approximately 31 x 2 hour session	Approximately 1,100
Capital District Health Authority, Public Health	Approximately x 6 hour workshops	Approximately 120
Capital District Health Authority	Pharmacology Microbiology – lab technology Physiotherapy Rheumatology Addictions and Mental Health Occupational Health	
Allied Health throughout Nova Scotia where program has been delivered	Long Term care Home Care Acute Care Student nurses Regional Residential Services Society (may be licensed through Community Services) Nursing Homes Physician Services VON Health Educator's Community Hospitals (rural) Emergency Health Services (EHS) IWK Children's Hospital	Examples: Mountain Lea Lodge Sydney Mines Seaview Manor Shannex facilities Northwood HomeCare Braeside Nursing Home Twin Oaks

The South Shore District Health Authority committed to have all 1,100 employees participate in the two hour awareness sessions preliminary to launching a respectful workplace initiative. The Capital District Health Authority required 120 Public Health employees to undertake the six hour workshop as part of a grievance settlement. While both programs were mandatory versus voluntary the respective undertakings yielded different outcomes.

Discussion

Quantitative data gathered in the evaluation process to capture satisfaction with the program 3.52/4, relevance 3.59/4 and facilitator knowledge 3.74/4 was consistent across the two groups. However some weeks following the PHS sessions, there was an expressed perception that bullying at work had actually increased. This prompted further analysis of the experience of the two health care districts.

SSDH made the sessions mandatory and allowed time during the work day or time in lieu for those attending. It was made known that all levels of the organization would be attending including the CEO, management and physicians, creating a sense of inclusiveness. The sessions were timed to precede the launch of a respectful workplace initiative, directed at changing culture.

Public Health Services (PHS) as part of CDHA made the sessions mandatory as one outcome of a prolonged grievance; therefore it may have been viewed as a punitive action. It was found that not all managers attended, and certainly not upper management within the PHS organization, and with no connection to the larger CDHA organization which has publicized its transformational work as world leading. Once the sessions were completed within Public Health no further follow-up occurred with the employer. This served to demonstrate incongruence between what was talked about and the reality. From a program delivery position the commitment to accountability and transparency principles that CDHA publically espouses was not apparent. We believe this did not foster a constructive cultural shift which was the original intent but rather served to heighten a sense of perceived injustice.

The challenge for workplaces is to ensure justice in the whole undertaking to address and remediate workplace bullying. Perceptions of justice have been identified as a core value in most organizations and workplaces with significant negative consequences in employee behaviour, attitiudes and health when there is a perception of a lack of fairness or justice. Facets of Justice Include:

- Distributive justice, concerns the fairness of the outcome or the decision made following a complaint process;
- Procedural Justice, concerns the fairness of the process, that there was a lack of bias in the investigation process of bullying and equal representation for the parties involved.
- Interactional Justice, concerns the personal interactions between the parties and includes;
  - Interpersonal factors, such as did the parties conduct themselves with honesty, respect and goodwill?
  - Informational justice, were explanations provided of how and why around decision making and outcomes.

In addition to eliminating bullying behaviors through policy, appropriate investigation, and sanction is the emerging field of restorative practices, which offers a common thread to tie together theory, research and practice in seemingly disparate fields, such as nursing, education, counselling, criminal justice, social work and organizational management. A restorative practice framework offers a range of approaches that give those most affected by conflict the tools and principles needed to resolve problems and build healthy relationships. The underlying premise of restorative practices is that people are happier, more cooperative, more productive and more likely to make positive changes when those in authority do things with them rather than to them or for them.

A restorative practice framework helps to explain human motivation and social behavior not only within families, classrooms, and communities, but within the social construct of the workplace including health care settings. With the stress and stretching of current resources in health care and no new monies in this province this is an approach that staff can adopt, utilize and transfer into other arenas of their work. An introduction using a restorative (workplace) practice can contribute to resolving conflict, repairing harm, and creating an overall healthy workplace culture. This practice is consistent with changes to the Nova Scotia's Human Rights legislation in 2012.

As a voluntary process, the guiding principles of restorative justice provide a different response to bullying than a traditional one. Rather than approaching a solution based on definitions of bullying or measures of frequency and intensity as a guide to sanctions; the focus is on understanding the harm that is done and how it can be repaired.

Wrongdoers, in this context people who use bullying behaviours in the workplace, need to be held accountable and answerable. Moreover, the needs of the person who has been harmed (target) are often overlooked even when perpetrators are sanctioned. Overlooking the needs of those who have been harmed can leave them continuing to feel invisible in the process. Formal discipline and sanctions may be a necessary aspect to repair harm and reintegrate individuals into communities of work; as resolving the harm done can serve to prevent it from happening again. A restorative practice model is an appropriate and beneficial tool to employ.

Summation

NSGEU's interest in the phenomenon of bullying and defining bullying as a form of workplace violence emerged from stories by workers about how they were being treated on the job. At the same time the definition and legislation dealing with psychological harassment in the workplace, and the release of respectful workplace policies was gaining momentum. The NSGEU made a significant commitment to its membership to address workplace bullying and publicly launched its Bully Free Workplace initiative in September 2010.

Member facilitators trained to deliver sessions have included two public health nurses, a community based rehabilitation counsellor and two social service workers from various areas in the province. The Nova Scotia Occupational Health and Safety Act [4] which states, *"Every employer has a duty to provide a safe and healthy workplace"* is an anchor to our program.

Research and development of this program followed a Grounded Theory Approach. Following the first year of a province wide pilot and evaluation, integrating quantitative and qualitative evaluation data confirmed the overwhelming positive acceptance of the program by both employees and their employers. Participant feedback quickly determined the need to advance the program beyond education in defining and naming the problem, to introducing intervention strategies.

Several questions have been considered such as: What are the dynamics of making the program mandatory, as part of an Occupational Health and Safety Program rather than as optional training? Additional results from the pilot to the present using collected data highlight positive, unexpected and potential future developments and long range possibilities. For example an on-line course through a virtual campus or delivery via a local college site is under consideration. One of the provinces largest long term care and homecare agency plan to trial a train the trainer model in 2012 based on a cost saving determination. The NSGEU Bully-Free Workplaces Program emphasizes quality assurance through research, development, evaluation and peer-to-peer facilitation. See Quality Assurance Table Appendix 1.

Examining two particular Nova Scotia health districts which received the NSGEU Program different outcomes were experienced. This led us to understand the role of perceived injustice. We also briefly considered a restorative workplace practice framework as an alternative to address issues of workplace bullying. A restorative practice can serve to change perceptions of injustice, thereby promoting healing.

We hold to the mission to be a leader in advancing the right to dignity on the job through delivery of programs to promote Bully-Free Workplaces and Restorative Practices.

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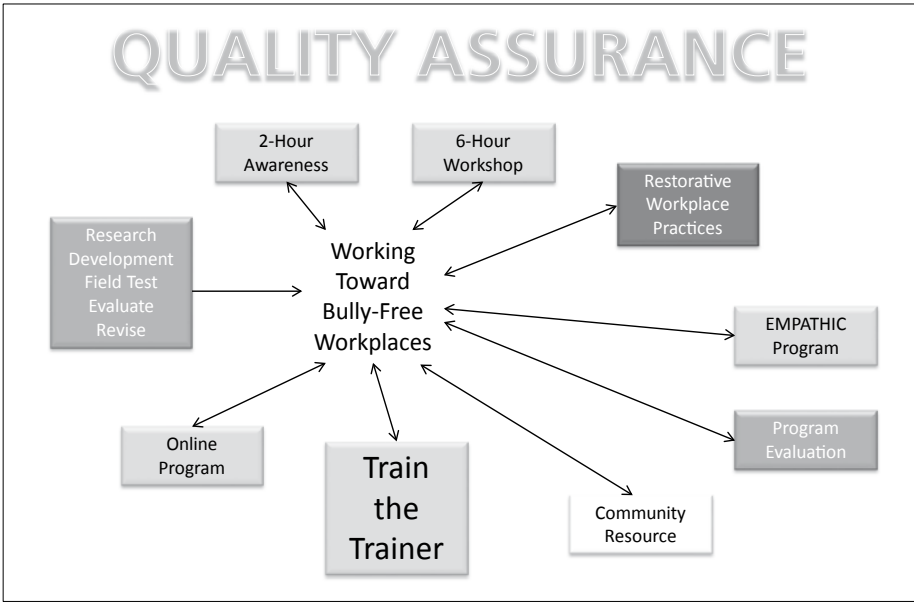
2. http://www.workplace-violence.info
3. ns.ca/lae/healthandsafety/pubs.asp
4. ns.ca/lae/healthandsafety/pubs.asp

Appendix 1. Quality Assurance



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Learning objectives

Deliver an educational program so participants will:
1. Identify and understand what bullying is.
2. Recognize the traumatic impact it has on the whole person, including witnesses/observers and the organization.
3. Be introduced to tools and remedies: Employer Policy, Restorative Practice.

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Situational factors contributing towards violence in the emergency department

Paper

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Focus: Research
Keywords: Violence, situational factors, emergency care, nursing

Introduction

This study explores a variety of situational factors that may contribute towards nursing staff experiencing workplace violence in the emergency department (ED). For the purposes of this paper the term situational factors relates to aggressor variables, victim variables, the situational/environmental context and the consequences for relevant stakeholders involved or affected by workplace violence.

Background

In relation to ED violence reviews of the literature have been conducted (Taylor and Rew 2010, Ferns 2005) and authors have reviewed and identified the following themes; defining violence and aggression in the ED, severity of assaults, injuries sustained and weapons utilised by assailants, the frequency of assaults, incidents of verbal abuse, characteristics of victims, the physical, psychological and organisational consequences of experiencing violence and the phenomenon of incidents not being formally reported. Characteristics of aggressors and the influence of trigger factors such as gender, age, a violent history, a psychiatric history, alcohol/substance misuse, clinical presentation, waiting times and timing of incidents, department geography, hospital security, gang activity, hospital catchment areas, aggressor consequences, staff education/training, staffing levels, skill mix, stress, job satisfaction and attitude have also been considered. However, Winstanley and Whittington (2004) suggest that there seems to have been little progress towards actually explaining the prevalence of aggression in any health sector. Subsequently, in order to contribute towards the development of new knowledge in this field this study was conducted to examine the perceptions of ED nursing staff in relation to identifying situational factors that may contribute to the development of violent situations in the ED.

Objective

The objective of the study was to explore the situational factors at play relating to violent incidents experienced by ED nursing staff.

Study design

The study was undertaken from August 2007 to May 2009 at a site specific ED in the South of England. Adopting an interpretive paradigm data were collected and analysed within a grounded theory framework. Data triangulation was employed, with the researcher conducting a retrospective documentary inspection of ED violent incidents forms completed by nursing staff (n=38), semi-structured interviews with ED nursing staff (n=9) and periods of non participant, unstructured observation (n=17, 52 hours). Ethical approval was confirmed prior to study commencement.

Participants

The inclusion criterion for participants required participants to be;

- a registered nurse
- employed as an emergency nurse with experience of caring and treating emergency service users
- currently practising in the ED
- willing to participate in the study

Data analysis

Data analysis was primarily guided through the Strauss and Corbin (1998) approach to grounded theory.

Findings

Hospital incident form (n=38) findings

Of thirty eight reported incidents, thirty six (94.74% n=38) involved patients and visitors, one incident (2.63% n=38) involved co-workers and one (2.63% n=38) involved an intruder. Three incident forms (8.10% n=37) specifically suggested waiting times were a trigger in the development of conflict with staff. Alcohol was implicated as a trigger factor in seven incidents involving service users (18.91% n=37). Incidents reported suggested 5 incidents (13.51% n=37) involved service users presenting with psychiatric histories although the

specific nature of these histories were omitted. Four (10.81% n=37) references were made to service users presenting with clinical conditions (abdominal bleeding, confusion, a head injury and a laceration). When reviewing incidents the majority of victims identified were qualified nursing staff (29, 76.31% n=38 MD=2). Incident form analysis suggested that conflict emerged through the day-to-day practicalities of delivering nursing care. Close proximity between staff and service users was an important factor. Five incidents described situations were nursing staff and service users clashed over requirements for treatment. Three incidents involved nursing staff projecting themselves as the victims advocate by proactive involvement following witnessing what can be perceived as acts of violence against others.

The onus for aggressive behaviour was frequently placed on the behaviour and attitude purely of the aggressors. However two themes emerged relating to this point. Not only did nursing staff enter into situations proactively upon witnessing violence they would also be involved in the development of incidents through either making a conscious decision to get involved in ongoing situations or set limits on the behaviour of others. Three incidents highlighted concerns of staff relating to the environmental security measures employed in the department or the response of individuals following the development of incidents.

Interview findings (n=9)

Aggressor characteristics

The hospital catchment area and characteristics of service users was raised by the participants. Participants suggested conflict was most likely to occur in situations involving; bereaved relatives or service users who had experienced stressful events such as being victims of violence. Service users presenting with cognitive impairment, hypoxia or dementia, psychiatric illness, alcohol misuse, a social class factor, polarised family units bringing conflict into the department, individuals with a low opinion of staff who use verbal abuse or violence on a day to day basis, gang criminality and individuals abusing or not understanding the role of the ED service were also highlighted.

Staff characteristics

Participants suggested the role of the nurse manager in the ED was to proactively manage incidents of violence. Negative role modelling encouraging a provocative or confrontational approach towards service users was also raised particularly when staff viewed service users as inappropriate attenders.

Specific situational/environmental characteristics

Participants suggested that the service infrastructure, stretched to breaking point due to increasing service user throughput was an important contributory factor. Participants also felt that staff were unable to meet their goals of providing high quality care due to the pressure of meeting published government targets such as processing service users through the department within four hours.

Consequences for relevant stakeholders

More experienced participants suggested that service users were less likely to police their own behaviour in comparison with experiences in their earlier careers. Participants varied in their opinion of their employing organisations response to violence in the ED. Some participants criticised the lack of managerial response and the response of the Police service towards dealing with aggressors whilst others highlighted the improved security infrastructure and the banning and exclusion of violent service users from attending the department. Participants suggested that prolonged exposure to verbal and physical abuse in the department could lead to individuals leaving the nursing profession altogether, resigning or developing an uncaring, hardened attitude towards service users. Inter-staff conflict could also occur if individual staff became unhappy with the way other staff managed or failed to assist in conflict situations.

Observational findings (n=17)

Seventeen separate observational periods were conducted; totalling fifty two hours over a twelve week time period. Over the observational period we observed 1 direct and 2 potential incidents of service user/staff conflict but also 8 service user/service user conflict situations. On these occasions, no nursing staff were present. Following conducting the observational component of the study the following points can be raised. First, access to both the corporate facility and department in question can, at best, be described as uncontrolled. The waiting room appeared to be an uncontrolled area, nursing staff conspicuous by their absence, where service users would complain, argue or threaten each other beyond the hearing of staff. Negative experiences observed for typical service users related to waiting included a lack of communication between service users and staff, queuing to register at reception, no vacant seating, minimal personal space due to the large numbers of people in the waiting area and close proximity to others who could be agitated, distressed, frustrated, angry, intoxicated, swearing, complaining of pain or sleeping. On occasions the waiting area was also very noisy, and one could smell alcohol or urine on entering the department. Routine practice involved staff caring for multiple patients and it was simply not possible for staff to remain in constant attendance with individual service users. Tasks took the individual nurse away from the immediate bedside which could compromise service user safety. In relation to alcohol affected service users we did observe that on the majority of occasion's alcohol affected service users tended to be present in the evening and at the weekend.

Discussion

The triangulated approach to data collection adopted by this study supports the consensus of opinion from the literature by authors such as Winstanley and Whittington (2004) that the most likely aggressor nurses will meet in the ED clinical area are service users or those accompanying service users.
This study supports the perspective that medical presentation, particularly symptoms of cognitive impairment resulting in confusional states, psychiatric histories, alcohol and substance misuse and gang criminality all potentially contributed to conflict between staff and ED attendees. The potentially stressful experiences of bereavement or being the original victim of criminal assaults were raised as further potential precursors to staff/service user conflict. Furthermore, the practicality of delivering personal nursing care does appear to increase the vulnerability of nursing staff to experiencing a range of conflict situations. The attitude towards ones role as a nurse also appears important as the incident form analysis suggested that staff appeared to place themselves in compromising and potentially dangerous situations motivated by a primary desire to help others.

The role of the hospital location and the general characteristics of the service users accessing the service were raised on multiple occasions. The perception that aggressors brought their lifestyle, attitudes and behaviour into the ED environment was frequently commented upon. The observational component of the study also identified that a dominant situational factor related to the behaviour of service users accessing the service.

The ED literature does emphasise the importance of not confronting aggression with aggression yet the interview component of this study suggests some staff actively engage in confrontations with service users (an approach other colleagues are aware of), and appear to be personally insulted when meeting behaviour in the workplace they find unacceptable. Interviewees also highlighted the perception that violent individuals were characterised as individuals who did not wait for a prolonged period prior to engaging in conflict with staff but immediately demanded prompt treatment. The observational component of the study also identified that confrontational individuals appeared to arrive at the department door in a hyperactive state rather than becoming increasingly frustrated as they waited for treatment. The perception that nursing staff are viewed by some service users as obstructing or delaying the ultimate goal of medical care suggested that some service users see the organisation of ED care as a negative, not positive, experience. Nursing staff were much more likely to be involved in confrontations with service users primarily because some nursing staff viewed themselves as departmental managers and limit setters.

In particular, the attitude of some staff towards service users was raised by all the interviewees. Interviewees emphasised the potentially judgemental, negative, confrontational and rude behaviour of certain staff towards service users resulting in poor communication between some staff and some service users. Both role modelling and shift leadership were areas raised during these discussions with interviewees emphasising the importance of positive, clear, high quality, senior nursing role modelling that could be projected from more experienced to less experienced colleagues.

A number of incident forms completed by staff made reference to failings in the security infrastructure and environmental problems such as staff isolation and uncontrolled access. Poor corporate security was also clearly identified during the observational component of the study. The increased throughput of service users was raised but this was countered by the perception that generally the service infrastructure had improved over recent years. Proximity of nursing staff to service users and the nature of delivering nursing care was a particular area raised during examining situational factors. Close proximity when treating service users gives potential aggressors ample opportunity to physically assault staff.

One specific situational factor raised during this work is the role of waiting times and the development of staff/service user confrontations. Generally three broad areas were raised during this work. First, the general perception from interviewees were that violent individuals arrived in a hyperactive state and in that respect waiting times played only a minimal role in the development of staff/service user confrontations. Second, in more general terms the perceived improved service infrastructure and faster processing of service users through the department had reduced waiting times and subsequently waiting times were perceived as not playing as much of a significant role in the development of confrontations as in the past. Third, a further issue that was raised by a number of interviewees was the perception that it was not necessarily the length of time service users waited for treatment but the lack of communication between service users and staff that contributed to a feeling of frustration leading to confrontations. Finally the negative impact for staff exposed to persistent verbal abuse, for example, was raised by participants who suggested individuals could become burnt out and develop negative attitudes. The sheer bravery and courage of nursing staff who were practising in extremely challenging circumstances and caring for potentially extremely frightening individuals also warrants reporting. The insight of caring staff who projected an empathetic non-judgmental appreciation of the social circumstances of some service users must also be applauded.

Conclusion

This study identified a cocktail of situational factors contributing to conflict in the ED studied. Due to the complexity of the nature of ED violence multiple strategies are required, both internal and external strategies, in order to improve the current situation. Policies and service initiatives require a holistic and inclusive approach as violence, as a phenomenon, should not be viewed as a separate, distinct corporate issue but considered within the wider fabric of service delivery.

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Learning objectives

- The nursing profession has a key role to play in reducing violence in the emergency department through improved research infastructures and improved working environments for emergency department nurses.

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Hospital Nursing Unit Mangers' Discussions of Workplace Bullying

Paper

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Focus: Practice
Keywords: Workplace bullying, hospitals, nursing, managers, discourse analysis

Introduction

While anyone might encounter bullying in their workplace, people who are employed in the healthcare sector seem to have a higher risk of experiencing bullying (Zapf, Escartin, Einarsen, Hoel, & Vartia, 2011). In the United States, prevalence among the general workforce is estimated to be around 9-13% (Workplace Bullying Institute, 2007; Workplace Bullying Institute & Zogby, 2010), while bullying among hospital based nurses in the United States is reported to be around 27-31% (Berry, Gillespie, Gates, & Schafer, 2012; Johnson & Rea, 2009; Simons, 2008).

Workplace bullying negatively affects the physical and mental health of targets. It also has negative consequences for health care organizations and for the profession of nursing. It has been linked both to employee turnover (Johnson & Rea, 2009; Laschinger, Grau, Finegan, & Wilk, 2010; Simons, 2008), and to the departure of nurses from the profession (Johnson & Rea, 2009; Simons, 2008). Nurse turnover is costly to health care organizations, has negative impacts on patient care and contributes to cyclical nursing shortages (Bratt, 2009). Nurses who leave the profession because of bullying can discourage others from entering the field of nursing, further exacerbating nursing shortages (Stevenson, Randle, & Grayling, 2006).

Nurses who experience workplace bullying, but who receive support and assistance from their managers are less likely to state they intend to look for another job, and are less likely to experience negative outcomes related to bullying (Laschinger, Leiter, Day, & Gilin, 2009; Quine, 2001). Unfortunately, many targets of workplace bullying report that their managers are not helpful (Gaffney, 2012; Hutchinson, Vickers, Wilkes, & Jackson, 2009; Vessey, DeMarco, Gaffney, & Budin, 2009). In addition, ineffective managerial responses to workplace bullying can actually exacerbate the problem (Zapf & Gross, 2001).

Despite the crucial role of managers in addressing workplace bullying, little is known about how they view the problem, and what they say they do to address it. One study reported that managers feel they have an ethical obligation to address bullying, but they do not always receive support from their organizations (Lindy & Schaefer, 2010). It is possible that managers' responses to bullying are inadequate because they have not received training or support from their organizations. It has also been hypothesized that individuals' responses to workplace bullying are dependent on their preconceived ideas about bullying (Altman, 2009). In order to help managers respond more effectively to workplace bullying, it is important to determine how they currently view the issue and how they say they handle reports of bullying.

Study aim

The aim of this study is to identify how hospital nursing unit managers characterize workplace bullying, and how they say they respond to incidences of bullying. The ultimate goal is to use this knowledge to develop interventions that can help managers deal with workplace bullying in an effective manner.

Methods

Data for this study was collected via individual interviews with hospital nursing unit managers. Participants were recruited via advertisement and snowball sampling. Each participant was interviewed twice; initial interviews averaged 75 minutes, second interviews averaged 40 minutes. Interviews were audiotaped and transcribed verbatim by a professional transcriptionist. Accuracy of transcripts was checked by the researcher. Approval for the study was granted by the IRB board of the University of Washington. Data was analyzed using Fairclough's method of critical discourse analysis (Fairclough, 2003, 2008).

Results

Sample: Fifteen hospital nursing unit managers from seven health care organizations in Washington State participated in this study. The age of participants ranged from 32-75 years (average 52.5). The number of years of experience as a manager was between 2 and 25 (average 9.4). The sample was fairly well educated; 10 had a master's degree, 4 had a baccalaureate degree, and 1 had an associate degree. Fourteen of the fifteen participants were female; and fourteen of the participants were White.

Characterization of workplace bullying: All of the participants in the study said they were aware of workplace bullying on their units. However, they also stated it was hard to deal with bullying because they did not always see it and had to rely on reports from their staff. They also report that the subtle nature of some of the bullying behaviors can make it difficult to initiate disciplinary actions.

Participants described a variety of bullying behaviors. Verbal bullying ranged from overt behaviors such as yelling, using obscenities, or saying cruel things to more subtle behaviors such as condescension or sarcasm. Verbal bullying also included gossiping about another person or criticizing another's dress or manner. Participants also said bullying often takes the form of inappropriate criticism of another's work. As one participant put it, bullying can be *"constant nitpicking at what people are doing or not doing"*. Ignoring others, not helping them, or not sharing important information were other common bullying behaviors described by participants.

Physical behaviors that were reported included subtle actions such as rolling ones' eyes, *"looks that kill"*, invading another's personal space, or expressing disapproval by actions such as *"tapping feet"*. Less subtle physical behaviors included pushing or brushing up against another person. Finally, physical bullying could take the form of slamming equipment or grabbing charts.

To get an idea of how bullying is labeled, participants were given a list of terms and asked to choose the ones that they prefer. Incivility and workplace bullying were the two terms most often endorsed. Other preferred terms are: horizontal, lateral or peer violence, workplace or lateral hostility; workplace or peer aggression; and psychological harassment. Several participants stated that they prefer not to use words such as bullying to describe these behaviors. Instead, they said that they prefer to focus on desirable behaviors, and that they use the organizational values to help them do this.

Responding to bullying: The manner in which study participants characterized their responses to bullying fall into three categories: ignoring it, informal interventions or formal disciplinary action. The first action, ignoring the behavior was most often cited as something that other managers did. However, two participants did mention they may ignore complaints of bullying either because they don't know what to do, they didn't want to become involved in a *"he said, she said"* situation, or because they feel like dealing with it takes time away from more pressing priorities. Both of these managers said they will address the behaviors if the target keeps coming back to them with complaints, or if they feel the behavior is escalating.

Informal actions included encouraging staff to confront the behavior, facilitating conversations between the two parties, investigating reports of negative behaviors, and engaging in informal counseling with the perpetrator of these behaviors. Encouraging staff to confront the behavior was cited as an action by ten of the participants. Participants said they encourage staff to confront the behavior themselves because, the bully might be unaware of the effects of their behavior, the manager is often not present when the behavior occurs, and dealing with the behavior as it occurs prevents it from escalating. Several participants said they will help targets of bullying figure out what to say, and that if targets of bullying feel they cannot confront the bully on their own, they will arrange a facilitated conversation.

Participants also discussed investigating complaints of bullying before engaging in informal counseling or formal disciplinary actions, *"because there's often two very different stories"*. After investigating complaints, informal counseling is often the next step that managers undertake. Managers who said the bullies acknowledged the behaviors, or seemed willing to change did not initiate formal disciplinary action. Some managers said they needed to see immediate behavior changes, while others described counseling nurses about their behaviors for months or years.

Formal disciplinary actions were initiated when bullies didn't acknowledge their behaviors, the behaviors escalated, or when staff started reporting feeling ill when working with the identified bully. Disciplining a bully was described as a *"long process"*, which could take six months to several years. Every participant in the study mentioned the need to be aware of the role of the union in this process. Formal disciplinary processes were often described as being complicated by grievances.

Disciplinary actions were most successful when managers had written documentation from multiple staff members. Barriers to successful disciplinary actions included the reluctance of staff to document behaviors, the subtle nature of some of the behaviors, and the fact that managers do not usually witness the behaviors themselves, but have to rely on hearsay. The outcomes of disciplinary processes included terminating the bully, or the bully quit. Two participants described ongoing disciplinary efforts with uncertain outcomes.

Discussion and Conclusion

The managers in this study seem to be aware that bullying can occur on their units, and describe a range of behaviors that are similar to those that have been identified by researchers who study workplace bullying. Therefore, it is unlikely that they do not respond to reports of bullying because they do not recognize the problem. The fact that several of them said they only responded when staff began complaining of feeling ill indicates that they might not be aware of the serious consequences of continued bullying and of the need for early intervention.

Managers describe a range of responses to bullying. Ignoring the behavior is undoubtedly the least effective. Another response, asking targets to confront the behaviors themselves may be effective in some cases. However,

it is not recommended in cases of serious bullying (Namie & Namie, 2009). This response can also make targets feel that their complaints are not being taken seriously (Gaffney, et al. 2012). If this tactic is used, managers need to follow-up with the targets to determine if it was effective.
Informal counseling was a common response cited by managers in this study. Experts in workplace bullying also state that informal interventions can be an effective means of managing workplace bullying (Rayner, 2011). However, informal interventions need to have a time limit. When bullying is allowed to continue for a long period of time, targets get the impression that nothing is being done.

The managers in this study describe formal disciplinary action as being successful only because the person who was engaging in the bullying behaviors ended up leaving. Formal disciplinary action does not seem to be successful in changing behaviors and retaining the employee. The length of time that it takes to complete this process can also contribute to the perception of targets that not enough is being done. To mitigate some of the negative effects of bullying, managers need to make sure that the needs of the target are being met while engaging in lengthy formal or informal interventions.
While this study is limited by the small sample size, the limited geographic area and the lack of a representative sample, it resulted in some important findings. Participants in this study did recognize bullying behaviors in the workplace, and seemed to take complaints seriously. Education that would help managers deal with bullying more effectively should include education about the negative outcomes of these behaviors and the need for early intervention to mitigate these. In addition, organizations need to make sure managers have the skills and knowledge to respond, either informally or formally, to complaints of bullying.

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Learning objectives

1. To describe how nursing unit managers discuss workplace bullying management and prevention.
2. To describe some of the ways in which nursing unit managers manage and prevent workplace bullying among their staff.

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Screening for patients at risk of acting out behaviour: Why nurses don't comply

Paper

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Focus: Research
Keywords: Nursing, emergency department, acting out behaviour, screening, patient aggression

Background

The rising prevalence of violence and abuse in the health care workplace setting compromises quality of care and jeopardizes the self-esteem and self-worth of health care providers. Health care professionals are subject to all forms of aggression and are amongst occupational groups that are at the greatest risk of workplace violence. Nurses face a risk for violence four times greater than workers in general (Wells & Bowers, 2002). The rates of violence and aggression toward nurses in Emergency Departments (ED) are reported to be particularly high (Luck, Jackson, & Usher, 2007; Ryan & Maguire, 2006).The latest account of on-the-job abuse of Canadian nurses suggests that ED nurses report high percentages of both physical (42%) and emotional abuse (69%) at work (Shields & Wilkins, 2009). Similar findings have been reported both provincially (Duncan et al., 2001; Hesketh et al., 2003) and internationally (Farrell, Bobrowski, & Bobrowski, 2006). Patients are considered primary perpetrators of both physical and verbal aggression toward nurses in the ED (Ryan & Maguire, 2006).

The adverse effects of experiencing both physical and emotional abuse at work are considerable. Physiological and psychological outcomes faced by nurses include physical injuries as a result of physical violence (e.g., bruises, lacerations), feelings of embarrassment and shame, depression, anxiety, and fear of patients (Fernandes et al., 1999; Ferns, 2005; Irwin, 2006). Furthermore, a survey of ED health care workers suggested that 95% of respondents reported moderate to severe levels of stress following an experience of physical assault, while 55% of respondents reported stress levels of similar severity after experiencing verbal abuse at work (Fernandes et al., 1999). Research also proposes a number of organizational outcomes that result from violence and abuse in health care settings, including impaired job performance and decreased productivity (Shields & Wilkins, 2009). Fernandes and colleagues (1999) indicated that almost half of their ED respondents (48%) reported significantly decreased job performance up to a week following a violent incident and 73% of respondents reported fearing their patients as a result of violence.

Though the reported amount of violence is already high, the existing research suggests that a considerable number of cases go unreported. Researchers suggest that up to 80% of patient aggression toward nurses is not reported (Erickson & Williams-Evans, 2000). In an investigation of Canadian ED health care professionals, Fernandes et al. (1999) noted that two-thirds of respondents (66%) who experienced verbal abuse never or rarely reported the abuse and 44% of health care professionals that experienced physical violence at work also rarely or never reported it. Researchers suggest that the under-reporting of experiences of abuse at work may be attributed, in part, to social tolerance of increasing levels of violence (Duncan et al., 2001). Furthermore, researchers suggest that assaults on nurses are often seen as *"part of the job"* and may even cease to be regarded as assaults (Erickson & Williams-Evans 2000; Ryan & Maguire, 2006). Similar reports have been made by Jansen and colleagues (2005) who reported that many nurses admit to becoming accustomed to aggression and violence at work (Jansen, Dassen & Jebbink, 2005). Other factors that may contribute to the under-reporting of aggression and violence at work include nurses' perception that no action will be taken anyway or that they will be held responsible for patients' acting out behaviours (Shield & Wilkins, 2009). Clearly, under-reporting renders any reliable estimates of the extent of violence against nurses difficult and supports the need to further investigate the impact of screening and reporting procedures on nurses' experiences of abuse at work.

Method

The purpose of this mixed method research study was to evaluate the effectiveness and accuracy of a Clinical Risk Assessment Procedure designed to identify patients at risk for acting out behaviour (AOB). The research questions included: 1. Are patients seen in the emergency department being screened for AOB; 2. Is the AOB protocol being implemented for patients identified as at risk for AOB; if not, why not?; 3. Does the clinical risk assessment tool accurately assess AOB.

A total of 31 registered nurses in the emergency department of a community hospital in a mid-size southwestern Ontario city participated in the assessment of the clinical risk assessment procedure. The participating nurses completed an AOB checklist for each patient they cared for in the emergency department (ED) over a 4 week period.

A chart audit was then completed to determine if patients assessed as high risk for AOB did in fact demonstrate aggressive behaviour during their hospital admission. Following the 4-week data collection period, focus groups were conducted with nurses from five different units including emergency, psychiatry, adult medical, surgical, and renal to learn about the nurses' experiences with patients who had been flagged as high risk for AOB. A total

of 30 nurses participated in the focus groups, sharing their experiences with the AOB procedure and their feelings about its usefulness and effectiveness .

Results and discussion

Of 964 ED patients, 829 were screened with the Clinical Risk Assessment Tool, supporting an 86% compliance rate with the screening process. The AOB screening procedure states that the presence of a single primary risk factor in a patient should result in the patient's designation as at risk for AOB. If the patient is screened as at risk for AOB the patient is given a purple armband to signify this designation to hospital staff, an AOB sticker is placed in the patient's chart and Patient Registration is to be notified of the patient's AOB designation. Primary risk factors include any of the following: previous AOB designation; history of aggression; current physical aggression; initiation of a Code White; current verbal aggression; history of mental health act form; mental health act form required; forensic patient ; drug/alcohol intoxication; medical or psychiatric condition associated with violent outbursts; medication that may cause impaired judgment or cognitive state. Nurses identified the occurrence of 71 primary risk factors and 10 secondary risk factors in all screened patients. Previous AOB designation was the most commonly reported primary risk factor for patients, with males twice as likely as females to have a previous AOB designation; 16 and 7, respectively. Female patients were slightly more likely to have been recorded as presenting with the primary risk factor of drug/alcohol intoxication than male patients; 7 and 6 respectively. However, male patients were more, or equally as likely as female patients to have been assessed as presenting with any other primary risk factors.

A total of 30 patients (4%) were classified at risk for AOB based on nurses' assessment using the Clinical Risk Assessment Tool. Out of the 30 patients deemed at risk for AOB, only two patients actually demonstrated Acting-Out Behaviour. A total of 10 patients exhibited aggressive behaviour throughout the research period. Only two patients that acted-out had been assessed as at risk of aggressive behaviour. Six out of the ten patients that demonstrated aggressive behaviour had been assessed using the Clinical Risk Assessment Tool and had been deemed not at risk of acting out; two patients had not been assessed using the Clinical Risk Assessment Tool. Males and females were equally as likely to act-out.
In contrast to the high rate of AOB screening compliance, rates of compliance for following the AOB designation procedures, that is, applying a purple armband, applying an AOB sticker, & informing Patient Registration of patient status, were extremely low; 13%, 23% and 33%, respectively. These findings suggest that nurses fulfill the minimal requirements of following procedure on assessing patients with the Clinical Risk Assessment Tool, but fail to follow through with the steps that result in the patient being designated as high risk for AOB.

During the focus group discussions the majority of the nurses acknowledged the usefulness of an instrument that could facilitate the prediction of violent behaviour exhibited by patients and the necessity of indicating this risk to agency staff , such as lab technicians and support staff, who may not possess in-depth information about patients' behaviour and their propensity for aggression and violence. However, when questioned about the effectiveness of the current Clinical Violence Risk Assessment tool, the majority of the participants reported that they found the instrument to be ineffective in predicting patient acting-out behaviour and directing violence prevention and intervention strategies. The focus group participants expressed concern about the instruments assessment criteria reliably predicting patient acting-out behaviours, and questioned whether a one-time assessment is sufficient to make such predictions. The situation becomes further complicated when the risk for acting-out behaviour is no longer present (i.e., the patient has recovered from an adverse drug reaction) and AOB designation and the armband remains. At this point the AOB designation and armband lack meaning, and do not facilitate the assessment and prediction of acting-out behaviour. From a practical standpoint, the armband is removable and the focus group participants reported that many of the patients who dislike being designated as AOB, will just remove the armband once the nurse or physician that gave them the armband leave the room.

Focus group participants voiced concern about patients who are labeled AOB upon admission to the hospital, based on a previous AOB designation; a sticker is applied to the chart flagging the patient as AOB. There is no information readily accessible that provides a context for the original AOB designation. To discover this information, employees would have to look up the patients' previous visits to the hospital and read the notes to determine the behaviour that warranted the AOB designation. Without this information, the focus group participants indicated feeling at a disadvantage in predicting the reoccurrence of aggressive behaviour and implementing patient specific strategies to prevent acting-out behaviour form happening again. Furthermore, if it is the patient's first visit to the hospital and they are designated as AOB, the use of the purple armband just calls attention to the risk the patient poses for acting-out behaviour, but does not indicate what type of behaviour one should be prepared to encounter. The effectiveness of the AOB designation in predict acting-out behaviour can be further compromised in the Psychiatric units of the hospital where high rates of acting-out behaviour is exhibited by patients with mental health concerns. The focus group participants who work in the Psychiatric units of the hospital reported that the majority of their patients are labeled AOB, and the designation is ineffective at conveying who is at risk for physically violent behaviour. A similar concern was expressed by an Emergency Department nurse who stated, *"every one we see on a Saturday night could be flagged AOB….so what's the point"*.

Recommendations

Several recommendations were proposed to improve the current Clinical Violence Risk Assessment tool. Focus group participants advocated that modifications to the assessment tool include on-going evaluations of indicators for acting-out behaviour. Further, focus group participants were strong proponents of the idea that the armband

only be used to identify patients who demonstrate immediate risk for acting- out behaviour and the armband be removed when the risk is no longer present. Due to the reported conflict that may arise from placing the armband on the patient and the ability of the patient to remove the armband, some of the focus group participants suggested attaching the visual AOB designation, whether it be a band or not, to the patients bed, rather than on the patient. The focus group participants reported being more accepting of the armband or some variation of it if its' application was implemented in this manner. Furthermore, the majority of the participants indicated that they would be more willing to apply the AOB designation to patients if the designation was not a permanent label attached to the patient.

In summary, this study revealed nurses accept and comply with conducting clinical violence risk assessments on patients. In contrast, once a patient is identified as being prone to violent behaviour, nurses are extremely reluctant to comply with the procedural guidelines to identify patients as being at risk for violence. The focus group discussions revealed several reasons that nurses do not adhere to their institutions procedural guidelines, with ethical concerns and lack of patient violence prevention effectiveness emerging as the most pertinent issues. The nurses offered several recommendations for revising the AOB designation and armband identification procedure however, it is inconclusive from the focus group discussions as to whether nurses would endorse and comply with the use of the AOB designation and armband identification in the future if modifications were made to the procedures. There appeared to be some disagreement among the participating nurses as to whether a system to label patients as violent or potentially violent should exist at all. To ensure AOB screening and designation procedures are effective in promoting safe work environments for the nurses who are providing care, as well as for the patients and families receiving care, it is recommended that nurses be actively included in future development and implementation of AOB policies.

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Learning objectives

1. To gain awareness of barriers to screening for acting our behaviours in an acute health care setting.
2. To identify strategies for implementing screening for acting out behavior in an acute health care setting.

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Violence against doctors in Iran's Khoramabad city hospitals in 2011

Paper

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Focus: Research
Key words: Violence, doctor, hospital, physician

Abstract

Background

Physicians often care for people in their worst physical and psychological condition. They are known to experience work related violence. Violence has a significant impact on doctors. Violence can also threaten the quality of medical service provided and people's health. This study tries to determine the incidence and causes of violence against doctors in Iran's hospitals.

Materials and methods

This is a descriptive and cross-sectional study. Eighty-six physicians filled out questionnaires. The data were collected and analyzed by SPSS software (version 18).

Results

Eighty-six physicians participated in the study - 69.8% male and 30.2% female, 55.8% general physicians and 44.2% specialists. Verbal violence was the most commonly reported form of work-related violence (82.6%): 19.8 % of the physicians reported exposure to at least one act of physical violence during the previous year. Common causes of violence were disagreement with the physician (60.9%), unreasonable demands of relatives (39%) and long waiting time (27.5%). Physicians' age, gender, hometown and specialization were not significantly associated with any type of work-related violence. Work-related violence was positively associated with physicians who worked at night.

Conclusion

Work-related violence exposure is common in Iran's hospitals. Cultural change and providing more information to people via TV and radio programmes, newspapers and schools may be required. Security guards must be increased in number in sensitive areas, such as the emergency department, and sensitive times, such as night shifts. Legislation will need to be passed to protect doctors.

Introduction

Doctors usually meet people in their worst physical and mental condition. Doctors are often exposed to work-related violence. Work- related violence has a significant impact on physicians and society. Previous studies have shown that effects of violence are psychological, social and professional (1). Some of these negative impacts include: post-traumatic stress syndrome (PTSD), depression, insomnia, fearfulness, taking time off, avoiding patients, avoiding sites, loss of job satisfaction, quitting job (1, 2).

Studies undertaken world-wide indicate that violence against doctors is a serious global health problem that needs more attention and appropriate measures. Although in Iranian culture the medical profession was considered a noble profession and people respected physicians, this public belief is changing day by day. We witness violence against health care workers including physicians in hospitals and clinics. Also, suspected murders of doctors (that some mass media reported as *"political killings"* (3)) indicate that violence against doctors has entered a dangerous phase in Iran.

Several studies on violence against doctors have been conducted in Kuwait, USA, Israel, Japan, UK, Australia, and other countries, but similar research had not been conducted in Iran. The aims of the present study were to access the experience of physicians in Iran regarding work-related violence, to detail their reaction to violent acts and to determine the causes of this violence.

Method

The study was conducted in Khorramabad (city and capital of Lorestan province (. Khorramabad is situated in the west of Iran and its population is over 500,000.

The psychiatric hospital was eliminated from the sample group because the reasons and incidence of violence perpetrated by patients with mental illness may be different from that of other patients. The sample consisted of all physicians who had practiced in Khorramabad's hospitals in the previous year.

In the present study, the data collection instrument was an anonymous questionnaire. The questionnaire included items covering demographics data, reports on exposure to verbal or physical violence in the previous year, physicians' reactions to the violence and their attitude towards it. The demographic information collected was age, gender, specialization, place of birth, and workplace. The questionnaire was piloted with 9 physicians, resulting in a clarification of questions and responses. These 9 physicians did not participate in the main study. The revised questionnaires were then distributed among the participants and retrieved after completion.

In this study, workplace violence was defined as *"incidents where staff are abused, threatened or assaulted in circumstances related to their work"*.(4) There are two categories of violence: verbal violence includes threats to cause harm and verbal abuse (yelling, swearing, intimidating, demeaning, public scolding, and/or sexual harassment using words).(4)

Collected data were analyzed using SPSS software (version 18). T-tests and $\chi 2$ tests were used as appropriate. Statistical significance was set at $P < 0.05$.

Results

Eighty six physicians of 121 potential respondents answered the questionnaires - the response rate was 71.07%. Twenty-six doctors were women (30.2 %) and 60 doctors were men (69.8%). Ten respondents were aged less than 30 years (11.6%), 42 were aged between 30 to 40 years (48.8%) and 34 were aged more than 40 years (39.6%). Fifty-two physicians were Khorramabad born (60.5%) and 34 were from other cities (39.5%). The demographic characteristics of the respondents are shown in Table 1.

Table1. Demographic characteristics of respondents

		n	%
Gender	Men	60	30.2
	Women	26	69.8
Age	<30	10	11.6
	30-40	42	48.8
	>40	34	39.6
Specialization	General physician (emergency physicians)	48	55.8
	Specialist	38	44.2
Birthplace (hometown)	From Khoramabad	52	60.5
	From other cities	34	39.5

This research determined that 71 of the respondents had experienced verbal violence (82.6%) and 17 had experienced physical violence in their workplace (19.8%) during the previous year. Six doctors reported being chased by attackers outside the hospital (6.9%) and 7 were threatened by telephone (8.1%). See Table 2.

In the present study, the physicians' age, gender, hometown and specialization were not significantly associated with any type of work-related violence.

Physical violence was positively associated with emergency physicians who worked at night and they were more likely to be victims of physical violence ($P<0.05$).

Table 2: Types of violent incidents

Experience	Yes (+)		no (-)		Total	
Types of violence	n	%	n	%	n	%
Verbal	71	82.6	15	17.4	86	100
Physical	17	19.8	69	80.2	86	100

Patients' family members or their friends perpetrated 79.8 % of the reported violent acts and 20.2% were committed by patients. Gender was significantly associated with violence against doctors ($p=0.001$) and men were more likely to be perpetrators of violence than women.

In this study, 23.2 % of the respondents were exposed to violent acts by the patient or patient's relatives who had an important position in the government, including local authorities, judges, clergymen, senior military officers and other authorities. The primary type of violence perpetrated by these persons was verbal violence but in 5%

of the incidents both verbal and physical violence was experienced. The present study showed that 60% of the influential people had threatened to expel doctors from their jobs.

The participants were questioned with regard to the site of violence. The sites of violence, in order of frequency, included emergency department (53.1%), doctor's examination room (46.9%), on the ward (30.2%), and in the hospital corridors (22.2 %).

A small percentage of violence acts occurred at dawn (10.7%), the majority occurred at night (54.5%). The most commonly reported reaction to verbal violence was trying to explain the problem (60.9%). Other reactions included silence and leaving the site of violence.

Respondents' reactions to physical violence showed that 46.2% of doctors informed the police; the others were silent: 56.8% of the non-reporting physicians cited lack of faith in the judicial system and police as the reason. 37% were satisfied with the attacker's apology. Other respondents said they could not go to court because they were committed to their job and did not have enough time to pursue the problem.

73.9% of the respondents having experienced violence believed that the patients were not in an emergency or acute condition and not in need of emergency medical intervention when the violent act occurred. Common causes of violence against doctors were disagreement with the physician (60.9%), unreasonable demands of relatives (39%) and long waiting time (27.5%).

Respondents' views on the reasons for the violence were analyzed. The great majority of participants (80.3%) believed that lack of laws to protect doctors is the reason. 60.8% of doctors said that the uncontrolled entry of the public to their hospital is another reason of violence. 39.5 % of doctors believed that the low number of security guards is the reason of violence against doctors. Most participants responded with at least two responses.

The Medical Council of Iran provides doctors with self-defense equipment including tear spray. In this study, it was found that 8.3% of the participants had been equipped with tear spray but had never used it against attackers.

The participants' attitude towards self-defense spray varied: 35.7% of them believed that the use of spray is an unethical act, 30% said that a self-defence spray can be helpful to protect against violence and 21.4% said that use of the spray is difficult and not feasible in various situations.

The impact of violence on physicians: 22.7% of respondents said that they had reduced their time of work or had changed their work shift, 22.7 % had to accept the patient's or their relatives' demands to prevent violence, 13.6% decided to change their workplace and 2.3% decided to change their location.

Discussion

Findings of the present study indicate that violence in Khorramabad's hospitals is a common phenomenon. In this study, 82.6% of doctors had experienced verbal violence and 19.8% had experienced physical violence.

This rate of verbal violence is consistent with studies undertaken in Kuwait and the state of Michigan where verbal violence incidences were found at 86% and 74.9% respectively. (5, 6) Studies in Japan and Israel, however, have reported lower rates of verbal violence against doctors (24.1% and 56%). (7, 8) It appears that socio-economic and psychological factors can vary in different countries and these differences can influence the phenomenon of violence.

In order to compare the results, there is no research on violence against doctors in Iran but there are some studies on violence against nurses. In Hormozgan (southern Iran) 2005, verbal violence levels were reported at 72.2% and physical violence at 9.1% in the previous 6 months. (9) A Tehran study in 2006 indicated that work-related violence against nurses was very high - 98.6% of responding nurses had experienced verbal violence and 37.7% physical violence. (10)

In another Tehran study, physical violence against nurses was found to be 29%. (11) In a study conducted in west Azerbaijan, Iran in 2008, 37.7% of the emergency personnel, reported acts of physical violence. (12) Comparing these results; it seems that physical violence against nurses is more frequent than acts of physical violence against doctors.

The present study indicates that general physicians who work at night have a high risk of being victims of work-related violence. Physician offices and clinics are closed at night and all patients must go to hospital emergency units. A small number of physicians, therefore, care for large numbers of patients. It may result in an increase of violent incidents in hospital emergency departments. This result shows that hospitals need more security at night.

Demographic data (age, gender, specialization and hometown) were not significantly associated with risk of being a victim of violence. The study shows that experiencing violence is not dependent on physicians' personal characteristics, and violence phenomenon can be considered as a socio-cultural problem that threatens all doctors regardless of gender, age, specialization and birthplace.

The present study also demonstrates that the most common cause of violent acts was disagreement with the physician. Some patients and their relatives would like to be involved in therapeutic decision making. The interference of patients, however, may result in harm to them. Their information and medical knowledge may be insufficient or incorrect, and unacceptable to physicians. This issue can make patients or their relatives resort to violence.

Rejections of relatives' unreasonable demands were also a trigger for violence. Some unreasonable demands push doctors to prescribe addictive drugs inappropriately (e.g. Morphine or Benzodiazepines) or involve illegal requests, such as writing fake medical certificates. When physicians reject these demands, violence against doctors may result.

To prevent violence against doctors, it is necessary for government (especially the Ministry of Health) to encourage the public to respect the professional independence of physicians and build confidence in doctors. Public training via mass media, schools, universities and other measures may be helpful.

More than half (53.8%) of the respondents did not report episodes of violence because of their lack of faith in the judicial system. Physicians believe that the police and courts will take no action. In addition, slow and long court cases discourage physicians from filing a complaint against their attacker.

In this study a high percentage of physicians believed that lack of laws to protect doctors encourage people to attack doctors. It is a true fact that there is no law to protect doctors in Iran. The police and judicial system should not neglect work-related violence. It seems it is important that the legislature pass laws to protect doctors against violence. Also it is important, to make violence against doctors as a non-bailable offence. The law can restrict people's attacks on doctors when they are on duty and they can help reduce the incidence of violence against doctors.

The uncontrolled entry of the public is also a causative factor behind work-related violence. It is important to restrict the public's entry to hospitals. Security must be provided to the doctors in the hospitals. Adequate numbers of security guards in hospital may decrease the violence. Security guards must be placed inside the hospitals in sensitive areas like the emergency department and at sensitive times like nights.

Waiting times should be shortened because long waiting time is a trigger for violence. This problem needs a solution. Increasing the number of doctors can help to reduce an overload of the health care system and doctors must not delay to visit the patients.

In recent years, the Medical Council of Iran has given self-defense equipment like tear spray to physicians. In this study, 8.3 % of participants said that they had tear spray but had never used it. Physicians' views about self-defense equipment vary: 35.7 % of physicians believed that using tear spray is an unethical act. Kowalenko et al (6) reported that a significant number of emergency physicians sought various forms of protection in the Michigan College Hospitals. This difference between physicians' viewpoints about the use of self-defence equipment in Iran and the USA may be because of cultural differences and different ethical codes in the two societies.

Self-defense equipment or martial arts may be useful to boost the doctors' confidence to deal with physical violence but further research needs to be conducted to identify the efficacy of self-defense equipment.

The present study indicates that violence has negative impacts on physicians' life and work. These impacts include limitation of working hours, changing work shift, changing residence and acceptance of patients' unreasonable demands because of fear of violent acts.

The study makes clear that violence against doctors is a serious and common phenomenon in the hospitals and needs special attention. Public training and cultural change may be required to prevent violence against physicians. This study has suggested some ways to prevent violence but further studies need to be conducted on work-related violence prevention and additional ways to deal with violent acts.

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Learning objectives

1. Participants will learn that physicians are at high risk of being victims of violence perpetrated by patients and their families or friends and that violence against doctors has negative consequences on doctors' life and work.
2. Participants will learn that violence is preventable and that the factors affecting the occurrence of violence can be identified and addressed.

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Dealing with aggression and violence: Training and support are parts of the puzzle

Poster

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Focus: Education and Training

Abstract

Healthcare professionals are confronted with violence in the workplace more than ever (Wang, Hayes, O'Brien-Pallas 2008). In daily life two natural answers come to mind when facing violence: fight or flight. However these responses are inappropriate in a hospital setting.
In order to help nursing personnel deal with violence, we developed an intervention strategy based on training and support with Georges Kohlrieser's (2009) attachment cycle, inspired by the work of John Bowlby (1988), as the theoretical foundation.
According to Kohlrieser, the way a violent behavior is seen and decoded is as important, if not more, than the skills used to deal with it. At the core of every violent incident, the same three fundamentals are found: 1) the *"violent"* person is detached and feels vulnerable; 2) the *"violent"* person sees the other as an object and will treat *"it"* accordingly; 3) the other will try to protect and defend himself, leading to escalation. Understanding this process is the most important part of the problem, as it will help initiate real negotiation: working on the bonding process instead of entering escalation.

Training has been designed to develop a clinical judgment based on Kohlrieser's attachment cycle. Skills are developed to improve communication, acquire negotiation techniques in order to de-escalate situations comporting a high level of aggression and promote the use of risk assessment tools. All courses include the theoretical basis, role-playing and the study of clinical cases. Several forms of training are available to best suit the needs of nurses. First, a hospital wide formal four day long continuing education workshop is offered four times per year. Second, special training workshops are devised and tailored to the specific needs of nurses in a clinical setting. Third, workshops are included in specialized post-graduate training for nurses. Finally, special courses have been created in the auxiliary nurses training program.
Support is available to health care workers and teams to help them cope with aggression and its sequels. A leaflet (Margairaz, Levasseur-Racine 2007) has been published to answer questions workers may have regarding workplace violence. Psychiatric liaison nurses may be called for help at anytime by physicians, nurses or nurses' auxiliaries. Other specialized personnel are accessible such as psychiatric consultation-liaison team, staff psychologist, hospital security personnel, hospital jurists and support from the Human Resources department.
Our experience shows that training helps healthcare workers, but there is still a need to formerly evaluate its benefits. We are working on it. Support is another important piece of the puzzle, as it may prevent violence or its sequels on personnel and patients. Organizational aspects of the problem should also be looked into further, as we need to implement risk assessment tools, create protocols and procedures for departments where none already exist, and reinforce the synergy between the different actors involved. There is still a long way to go to finish the puzzle, but we are on our way. One piece after another.

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Learning objectives

1. Understanding the three fundamentals about violence is the first step to take to deal effectively with the problem.
2. Training and support are important and effective, but should also be accompanied by other measures (procedures, organisational aspects, support, follow-up, etc.) to be optimal.

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How men manage workplace bullying

Paper

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Focus: Research

Abstract

Workplace bullying is a leading type of workplace abuse and consists of offensive or unwanted behaviours that humiliate or intimidate another at work. The reported incidence varies with type of abuse and measurement methods but world-wide rates are reported to be increasing. Health effects include long term social, physiological, psychological, and economic symptoms. Our past research showed how workplace bullying influenced womens' health promotion and workforce engagement. We recognized a need to study mens' experiences because of potential differences in biology, gender norms, and help seeking behaviours.

We used grounded theory to study and develop a substantive theory of how men took care of their health and engaged in the workforce following workplace bullying. We recruited a community sample and interviewed 36 adult men who worked in professional and non-professional roles, unionized and non-unionized workplaces, urban and rural locations, and large and very small workplaces. Ages and education varied.

I briefly outline the main problem for men experiencing workplace bullying and the process they used to address it. Then I talk about how men manage workplace bullying and what they believe needs to be done to help men manage, including policy and workplace culture change strategies. Contrary to some popular perceptions, most men did seek help from available resources and I talk about the sources of help men accessed, helping methods used, and outcomes of help-seeking for the men. Some men in the sample worked in the health care sector and the strategies these men used were similar to those used by men not working in health care. I talk about implications for creating respectful workplaces which are applicable across all kinds of workplaces.

Learning objectives

1. Workplace bullying is devastating to mens' work lives and personal lives and men access many resources to help them manage bullying.
2. Workplace cultures need to change to enable more respectful interactions that protect men from bullying.

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Using a trauma based approach to promote the education of troubled adolescents

Paper

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Focus: Practice

Kibble Education and Care Centre in Scotland is a charitable organisation that works primarily with adolescents who are troubled and in trouble. The Centre offers a range of services that include an eighteen bed secure unit, open residential units, a fostering service and a community based day service. On campus are two schools (one based in the secure unit, the other in the open campus) offering full secondary education.
The structures in place for the young people resident in Kibble, the *"wrap around"* pro-social modelling and the excellent relationships with staff tend to ensure that, after what can be a troubled initial placement, the young people largely settle in to the rhythms of school life, responding well to the rich curriculum and the various incentives on offer for positive behaviour.

Historically, and perhaps counter-intuitively, the most challenging young people, and those whose placements were most likely to fail, were the community based day pupils. Not deemed to be in so much risk as to be placed in Kibble's high tariff secure or open residential units, these young people were living in the family home, in kinship care or in lower tariff local authority care. Factors in their placement as day pupils at Kibble open school do, however, indicate the troubled nature of these young people. The choice by placing authorities of Kibble as their secondary school destination was based on previous multiple school exclusions (most often due to violent or out of control behaviour), non-attendance, being out of control within the family or children's unit or anti-social behaviour in the local community. A 2011 survey of the day pupils indicated that, prior to placement, 85% were involved in offending behaviour including violence and gang related activities. 60% had been recorded as having issues with drug and alcohol abuse and a further 28% had a record of concerning sexualised behaviour. Over half the young people had recorded mental health issues with 35% displaying significant anxiety and depression and 16% were self harming.

In spite of the intensive support on offer, with small classes and with highly trained care staff to act as mentors and to encourage the young people to talk through their problems, we were encountering difficult to understand and often bizarre behaviours. The incentives in place to encourage positive engagement were failing to have the desired impact. Punitive responses only led to a vicious circle of punishment – violent response – punishment with little movement or progress. We understood that we had only a limited amount of time to turn around such troubled lives and that we had little control over what was happening outside school hours. We knew that many of these young people were leaving chaotic situations each morning only to return to more chaos at the end of the day. We also understood that we needed to acquire a greater depth of understanding of the underlying reasons for these behaviours.

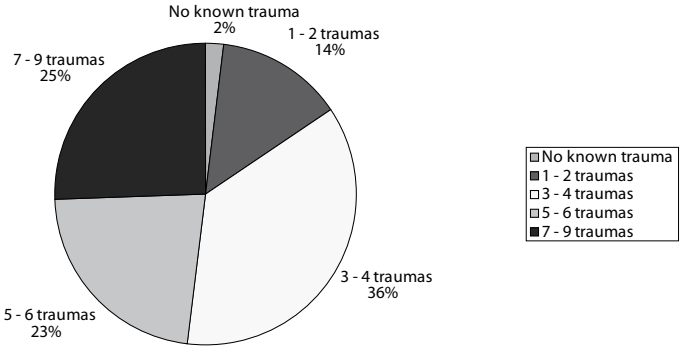
In 2009, Kibble brought Bruce Perry, the neuroscientist and child psychiatrist, from the US to deliver master classes to our staff on brain development. The understanding these classes gave us on the effect of trauma on the brain were somewhat akin to a *"eureka"* moment. We recognised the behaviours that Perry identified as being the result of childhood trauma and neglect. We began to unravel the histories of our children in terms of possible trauma incidents or experiences. These included: numerous non-family placements, parental separation, sibling separation, a parent or parents in prison, witnessing parental substance abuse, witnessing family and/or community violence, sexual abuse, physical abuse, neglect. While any one of such experiences can prove to be disabling to a child, we found that many of the children in our community based service had been subjected to multiple trauma experiences which continued to be ongoing.

Figure 1 indicates the burden of multiple trauma experiences that was being carried by our young students. Having identified these experiences and with the new found knowledge of the effects of such experiences on the growing brain, we had to rethink some of our more tried and tested strategies.

We became more aware of our effect on the young people and this awareness informed recruitment and training. The ability to form relationships quickly, the ability to put young people at ease and have fun with them and self awareness of body language and tone of voice all became essential factors in selection of staff and staff supervision. We also became more aware of the language that we used amongst ourselves to describe behaviour. Certain expressions (e.g. being manipulative, out of control, totally controlled) were banned. A nurturing approach was affirmed.

Each young person coming in to our day programme is allocated a key worker. This role became core to our new strategy - building a relationship with the child and the family, being a pro-social model and enabling *"talking out"* rather than *"acting out"*. The key worker practises new skills with the young person and, most importantly, provides occasions for fun and laughter.

Figure 1 Multiple Trauma Experiences of Kibble Day Pupils



We realised that a calm environment was also important. We doubled the number of day units from two to four thus providing more quiet spaces. A multi sensory snoezlen room was also created which provided a safe space for a troubled youngster to calm down.

Bruce Perry recommends repetitive rhythmic activities as a means of calming traumatised children and we became more pro-active in building activities such as dance and drumming into our programmes. Fishing trips became a regular feature as well as an afternoon a week of *"playtime"*. Some of our most troubled young people have had little or no experience of childhood play and, accordingly, we built in regular trips to a local park or woodland to give them the opportunity to run around playing children's games. In the summer months, trips to the seaside were organised with the teenagers sometimes squabbling over the colours of buckets and spades!

For many of these youngsters formal classrooms were a major source of stress. It was important that teaching staff as well as the care staff were brought on board. They were also trained on the effects of trauma on the growing brain and were encouraged to take a more nurturing approach in their classrooms. The young people were encouraged to go to formal classes but were never forced if they did not want to. Instead, they could remain within their day unit, sometimes doing school work with their key worker. For the most part, most of the young people eventually chose to go to class.

Evaluation of the Service

"The only thing worse than failing and not knowing why you failed, is succeeding and not knowing why you succeeded." (Jane Timmons-Mitchell)

Our community based placements are referred to Kibble by local authorities who buy placements for their troubled young people who have been excluded from the state education system. As a service provider, we also have to be confident that the placing authorities are getting value for money and our approach is achieving the desired outcomes.

To this end we carried out a systematic evaluation of the service in the hope that excellent practice could be highlighted (and maintained!) and that areas for improvement could be identified. The quality indicators that we used are set out below:

- Placing Authorities evaluations
- Attendance statistics
- Attainment statistics
- Parental evaluations
- Service users evaluations
- Management of critical incidents (restraints)
- Placement maintenance

Placing Authorities

Placing authorities were first asked what their expectations of the Kibble Day placement were. Their responses are set out below.

Placing Authority 1:	Attendance, structure and reduction in offending. The breaking of the cycle of despair. Hope. Building of resilience
Placing Authority 2:	Emotional well-being and an impact on difficult and challenging behaviour.
Placing Authority 3:	Greater pro-social integration, re-engagement and reduction in offending
Placing Authority 4:	Re-engagement with education, improved interpersonal skills and raised self esteem

Placing Authority 5: Improved attendance and attainment for the young person, along with improvements in behaviour.
Placing Authority 6: Re-engagement in education, improved self-esteem, trust in adults, not another failed placement.

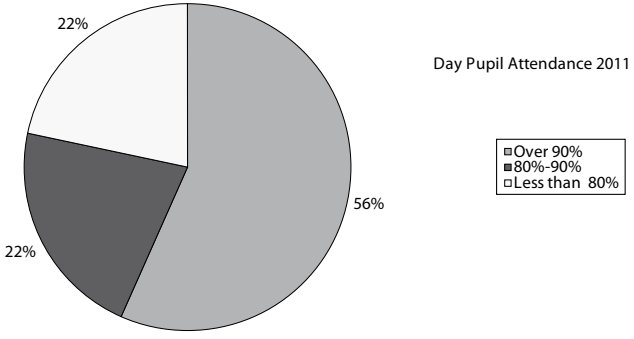
The expectations of these stakeholders were either partly met (one stakeholder), met or exceeded. Their responses to the question *"What is the key positive impact of the placement"* are set out below:

Placing Authority 1: We like how Kibble works hard to maintain difficult placements. There is a high level of support and structure within day units.
Placing Authority 2: Day Services staff show a positive regard for children while providing clear boundaries. They do the job the parents should be doing.
Placing Authority 3: Good attendance from a near zero baseline and constructive participation in the learning process.
Placing Authority 4: Increased attendance, reduced level of risk taking, increased level of engagement with education.
Placing Authority 5: I believe the placement has brought daily routine and structure for the young person and has allowed him to achieve personal goals which have in turn increased his confidence and self esteem. Staff also encourage the young person to reflect on negative behaviour and overcome barriers in order to move forward and progress.
Placing Authority 6: The young person has gained confidence in his literacy skills. He has increased an ability to self-regulate; although he still has outbursts he can be effectively managed and helped to reflect on his behaviour. He is less reactive.

Attendance

As can be seen from above, attendance was a key expectation from the placing authorities, particularly as poor or non-attendance had been a feature of previous placements.

Figure 2: Attendance



We found unexpectedly high rates of attendance with 12% of young people achieving an attendance rate of 100% over the year and 40% attaining an attendance rate of over 95%. Of those (22%) achieving less than 80%, only one young person had an attendance of under 70%. School had become an important aspect of their lives, a place where they clearly wanted to be.

Attainment

National statistics in the UK suggest that Looked After Children have poor educational outcomes with about one quarter leaving school with no qualifications.

In 2011, all Kibble day pupils left school with some qualifications. 73% achieved a national qualification in English and 64% achieved a national qualification in maths. In terms of attainment, the young people attending the Kibble Day Service, while not matching the outcomes of their peers in mainstream settings, achieved considerably better educational outcomes than Looked After Children nationally.

Parental Evaluation

We wanted to find out if parents felt that there had been an impact on their children's presenting problems, particularly offending behaviour in the community and being beyond parental control. The feedback was overwhelmingly positive. 100% reported that their sons/daughters had been better behaved in the community since starting their placement at Kibble. 93% reported that their children had picked up fewer police charges. 87% reported better behaviour in the family home and 73% reported an improvement in resolving problems.

Young Person Evaluation

Each young person attending Day Services was asked to fill in a questionnaire evaluating his or her time at Kibble. The young people were asked about the support and guidance they receive from staff and whether they felt fairly treated, respected and listened to.

- 100% said they were fairly treated when their behaviour required intervention
- 96% said staff offered them respect
- 96% said staff made an effort to praise appropriate behaviour
- 100% said staff offered appropriate guidance and support when negative behaviour is identified.

Crisis Management

Young people come to Kibble Day Services with a history of failed placements. In most cases the principal reason for former placement breakdown had been unmanageable behaviour, including violent attacks on staff. Kibble trains staff to work with some of the most damaged young people in Scotland. This training centres round de-escalation techniques. However, we also recognise that, for the safety of young people and staff, there are times when a physical intervention, or restraint, has to occur. These restraints are closely monitored on a monthly basis to ensure that best practice guidelines are adhered to – that is, the physical intervention was made on the grounds of safety rather than compliance, that the least restrictive form of intervention was used to maintain safety and that the intervention was for the minimum duration to maintain safety

Figure 3: Frequency of restraint and use of restrictive holds on day pupils: 2010 and 2011*
*(*Based on calculating number of restraints against number of young people and number of days)*

	Frequency of restraint	Use of restrictive floor hold
2010	0.04	65%
2011	0.009	49%

Restraints were used on 18 occasions in the course of 2011, a number down on that for 2010. A factor to be considered as well as frequency of restraint is the level of restrictiveness involved. Kibble encourages staff to use the less restrictive standing hold. Floor holds should be used only when the young person can not be held safely in a standing hold. As Figure 3 indicates, the more restrictive holds were used less frequently in 2011.

Placement Retention

An important measure of success has to be the ability to break the cycle of failed placements and ensure a successful transition to employment or further education or training. In the course of 2011, of the 11 who left the service, 7 enjoyed a successful completion to their education: two to continue in further education, five to start an employment training programme and one to start employment in his local area. Two of our pupils were transferred to a residential placement within Kibble and one young person took up a residential placement in another area. The placement of one young person was terminated due to his refusal to engage. The remaining 29 young people continued to enjoy a successful placement.

Conclusion

In 2010, a trauma informed approach was affirmed for Kibble's community based day pupils. One year on, the positive feedback from parents, placing authorities and the young people themselves as well as success in achieving high rates of attendance and attainment, reducing frequency of critical incidents and achieving successful endings would indicate that this is an approach that works for children and young people with multiple trauma experiences.

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Dr Bruce Perry (Child Trauma Academy, Texas, www.childtrauma.org); Alasdair Black, Operations Manager, Kibble Education and Care Centre, alasdair.black@kibble.org; Neil Govan, Depute Head Teacher, Kibble Education and Care Centre, neil.govan@kibble.org.

Learning objectives

1. That trauma based practice can have a positive impact on troubled adolescents.
2. That more meaningful learning takes place when the roots of distress are first addressed by a calming environment.

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The tragedy of women's self-immolation in Iran and developing communities: A review study

Poster

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Focus: Policy

Abstract

Suicide is a particularly awful way to die and one of the most historical psycho-social crises of human society worldwide. It is as the result of an act deliberately initiated and performed by a person in the full knowledge or expectation of its fatal outcome. While suicide by self-immolation is very rare in developed world, it is more frequent in Africa, Middle East, Far East, Egypt, India, and Vietnam, where it is somehow linked to religious believes. Suicide rate has been ranged from10 per 100,000 person /year in Ireland and Egypt, and up to 35 per 100,000 person /year in Baltic region. Iran also is the 96th country in terms of suicide rate. There are many different methods and means of deliberate self-injury according to culture, symbol and religion. Non-accidental severe burns are considered as significant social and medical disorder in economically developed and developing countries. Assault and self immolation are two mechanisms of burning classifi ed as non-accidental injuries, both attracting forensic considerations. Self inflicted burns may be an attempt at suicide (self immolation) or part of a continual urge towards the deliberate self harm process. The present review articles aimed to assess the epidemiology of self immolation phenomenon as a worldwide problem and in Iran and developing communities in particular. The main victims of this awful way of death are women that are the most vulnerable group in these societies.

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Rethinking workplace violence prevention: Moving to a new paradigm focused on using predictive management techniques

Workshop

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Focus: Practice
Keywords: Predictive management, prevention thru design

Introduction

The intent of this paper is to further the discussion about the concept of 'Prevention Thru Design' (PtD) and to integrate it with Predictive Management principles. The Prevention Thru Design Initiative in which NIOSH has partnered with the American Industrial Hygiene Association (AIHA), the American Society of Safety Engineers (ASSE), the Center to Protect Workers' Rights, Kaiser Permanente, Liberty Mutual, the National Safety Council (NSC), the Occupational Safety and Health Administration (OSHA), ORC Worldwide, and the Regenstrief Center for Healthcare Engineering to develop a National Initiative on Prevention through Design was a very important step forward. Given that the ultimate goal of the Prevention Thru Design Initiative is to prevent or reduce occupational injuries, illnesses, and fatalities through the inclusion of prevention considerations into all designs that impact workers we believe that this is another step towards achieving the goal.

The concept of 'Prevention Thru Design refers to a conscious and purposeful design of an organization's systems, processes, tools and resources work collectively to achieve the desired goal of building violence prevention into the fiber of how the organization operates. Success in achieving this goal is dependent on the courage and fortitude of leaders to comprehend and adhere to unwavering premise of organization design. *"Organizations will achieve with amazing accuracy what they are actually designed to achieve"* (note this does not include designs that express the intent to achieve a desired goal, but are not specifically designed to accomplish it.).

Practical guidance to healthcare and social assistance employers is emerging from lessons from predictive policing, industrial hygiene, public health, product and building design, human resources/business analytics, behavioral science. Behavior pattern recognition and security technology. In addition, leaders must embrace a systemic approach within a business, from top to bottom, and involve workers at all levels within an organization. Its integration should embrace interrelationship of patient safety, worker safety, and environmental safety as well as extend outside the company as well – to customers, consumers, suppliers, first responders and the community.

Another fundamental issue necessary to achieve PtD is the need for a shift in management paradigm, culture and leadership in the healthcare system, by developing a vision aligned with sustainability and patient safety. The Center to Protect Worker Rights (CPWR) and its impact on construction has been identified as a possible model to imitate for the healthcare sector.

Finally, the entire PtD process must be driven by research –e.g., evidence-based research that shows that PtD positively impacts patients, workers, and the community. Credible research including primary and applied research will provide a source of leverage to promulgate PtD throughout industry.

Discussion

Zero tolerance equates to reactive management and communicates the message to employees 'when something happens this is what the organization will do.' This practice is akin to the infamous response that use to be heard from many police departments when they were called to the scene where trouble was brewing, but a crime had not yet happen – *"call me back when something happens and we will take care of it."* The problem with both of these approaches is that they wait for an incident or policy/law violation to occur which means, by definition, you are now reacting to a situation where someone may have already been injured. This approach basically leads to conflict management, crisis management, 'fire-fighting' or worse case injuries.

A positive proactive alternative approach being pioneered by the police departments promises to change the police response forever - police are using a new statistical model to predict crime and try to prevent it. The Santa Cruz (CA) Police Department submitted eight years of crime reports to an applied mathematics professor at Santa Clara University, and he is mapping the time, location and recurrence of crimes to help police predict crime and tailor their patrols. It's an emerging, movement called *"predictive policing"*.

Likewise progressive organizations are now embracing a new approach which deals with organizational problems by focusing on detecting problematic situations, anticipating issues that may lead to conflicts, cause

problems, etc. and then preemptively implementing preventative measures to reduce the likelihood of conflicts, policy violations or incidents occurring in the first place.
The desired end result we are seeking is to form a community of aligned organizations to build a workplace violence prevention framework that organizations of all types will be able to use to move significantly closer to the ultimate goal of eliminating incidents of violence and having a safe and secure workplace.

The Predictive Management Paradigm

According to F. John Reh, a contributing author to Business: The Ultimate Resource, many managers believe that their job is to resolve problems that arise. While that is true, it is only the lesser part of the job. More importantly, a manager's job is to prevent problems. This is the difference between reactive management, which solves problems as they occur, and predictive management, which tries to prevent many problems from arising in the first place.

Reactive management deals with problems as they come up

Predictive management focuses on reducing the number of problems that require reactive management. A predictive management style is an important competency for a manager to have. Predictive management does not replace reactive management, but it reduces the need for it. [1]
A classic example of predictive management is the transformation of servicing computer equipment from measuring 'mean time between failures' which meant that the equipment had broken down and needs to be repaired so a technician is dispatched to fix the problem. The contemporary predictive approach identifies 'mean time before failure.' This approach based on researching the normative information about time to failures, usage rates, work conditions, etc. and identifying when the equipment will need repair before it brakes down. In this approach a technician is dispatch to service the equipment before it is not operative and the customer experiences no downtime.

One of the first key activities of predictive management is to have clearly established standards of performance for key performance indicators that will lead to achievement of the organizations goals. To illustrate let's assume that one of the key performance indicators that has been established for the organization is to have a pre-determined level of employee engagement and one of the measures under this is the level of employee complaints. Accordingly, if the organization established a target to have less then 3% of employees file a complaint per month then we can establish a metric to track this.

A typical reactive management approach would be to track the metric and whenever the metric is exceeded to figure out what happen to cause the spike in complaints and then address these issues to try to mitigate or eliminate them. Whereas a predictive management approach would be to track the metric as well, but the focus of the efforts would be to diagnose the nature and history of employee complaints and to identify the top issues that cause complaints. Once these top issues are identified to then gain a clear understanding of the root causes that lead to these issues occurring and then developing actions to mitigate and/or eliminate the root causes to prevent the issues from occurring again, thus seriously eroding complaints from these specific issues. In addition, the predictive management approach would call for tracking the trend line of complaints as it is ticking upward and preemptively intervening to find out what is causing the upward trend. In the end, the predictive management approach focuses on achievement of the targeted goal level of complaints by early intervention before 'a problem' occurs versus waiting for an acceptable level to be breached and then reacting to try to get the complaint level back to an acceptable range.
Predictive management prevents bad outcomes before they occur, focuses management on the means to achieve key performance indicators, saves time and better uses resources. *"It will almost always be cheaper and easier to prevent a problem, or to minimize a problem, than it will to fix it,"* according to Steve Minter of Industry Week (January 2011 edition, p. 4).

As is the case with many major initiatives to address organizational problems, the success of a predictive management approach *"lies in whether organizational leaders see the imperative of continuously improving their safety [and security] culture -- that deep-down core value that employees across the organization share for safety [and security] -- and have the vision and will to make an improved culture a reality."*

According to Jac Fitz-Enz (2010) being able to foretell what is likely to happen with a high degree of probability depends on four things:
1. Comprehension of past and current events,
2. Understanding not only trends but also the drivers behind them,
3. Being able to see patterns of consistency as well as change and
4. Having tools to describe the probability of something in the future.

With the advent of human resources analytics (HRA) we are now at the threshold of being able to make this reality. HRA turns human resources metrics toward the future. It takes past and current strategic and operational data and adds leading indicators. Data on retention, readiness, leadership, and engagement speak to what is likely to come tomorrow. Indeed, this is the newest lever in the business intelligence machine.

Today, organizations are huge pools of objective data, as well as subjective knowledge, attitudes, and beliefs. the tools to manipulate and make sense of that data—By applying electronic and behavioral science technologies

tools, predictive management uncovers the connections and interdependencies among organizational activities. Study of the outcomes at the strategic, operational, and leading indicator levels yields insights into the future. It tells not only what, how, and why something happened yesterday, but, most importantly, also what is the likelihood of something happening tomorrow.

Most organizations have clear, visible outcome metrics for safety and security performance. But these measures -- including injury rates and related data -- are lagging indicators which is consistent with reactive thinking. Safety [and security] visionaries know that leading indicators are needed to assess exposures before accidents happen. Leading indicators such as the frequency of safety [and security] observations and feedback, and the amount of time it takes for a safety [and security] issue to be addressed, are better day-to-day measures. Near-misses, when received in the C-suite as an opportunity to improve rather than simply bad news that could have been worse except for a twist of fate, can lead to significant improvement in downstream outcomes.[2]
The start of implementing a predictive management approach to workplace violence prevention is to classify 'at risk' behaviors so that appropriate actions that need to be taken at each of the commensurate levels of risk can be defined. One model, which borrows from the threat levels used for Homeland Security, can be used to guide actions.[3]

Low Low risk of workplace violence incident
Guarded General risk of workplace violence incident
High High risk of workplace violence incident
Elevated Significant risk of workplace violence incident
Severe Severe risk of workplace violence incident

It should be noted that to successfully implement the actions necessary at each level an infrastructure for dealing with workplace violence must already exist. Typically this would include:
It should be noted that the 'low risk' level is the point where actions must start prevention efforts. 'Doing the right things' upfront to reduce the likelihood of situations escalating to higher risk level is at the heart of a predictive management approach.
Predictive management is not about using a 'crystal ball or Ouija board,' but more so, about using

historical data, research, root cause analysis and common sense solutions to address identified causes of problems. It is good solid management.

The essence of this approach is characterized by the following:
- Plan – the development of a business plan and strategy to guide the implementation of plan to prevent incidents of workplace violence.
- Detect – focuses on predictive strategies to identify potential 'at risk' behaviors and problems areas that should be address based on potential to be a catalyst to violence occurring; pre-emptive actions targeted at mitigating or eliminating underlying root causes of violence.
- Prevent – implementation of programmatic efforts to address detected issues and anticipation of potential problems; process to deal with possible problematic situations before violence actually erupts.
- Protect – implementation of established crisis management plan developed to address violence once incident is imminent or in process.

One of the leading obstacles to developing a proactive preventative approach to reducing violence in the workplace is to face the reality that most senior executives and managers are in denial and believe that *"it couldn't happen here"* or that the probability of it happening is so small we will do not need to be concerned. This view can also be characterized as *"if it happens we will deal with it,"* posthumously or we accept that there is collateral damage when you run an organization, to achieve the good that we contribute some casualties are to be expected. Overcoming this mindset is the starting point to implementing a strong and effective effort to prevent workplace violence.

Summary

To summarize, many managers view workplace violence as either a very low risk or random set of behaviors that are unpredictable and therefore nothing can be done to address them. While we can't eliminate all incidents we can anticipate where incidents might occur and take proactive steps to deter or prevent them. In addition, we have to move past placing all our energy and focus on individual behaviors and understand that organizations are not blameless and can be a contributor to the escalation of violence.

Acts of workplace violence can be reduced and many costs can be avoided with forethought, strategic planning, implementing predictive management principles and taking proactive action – anticipating our organization becoming a target of violence is not wishful thinking, but instead it is prudent and good business decision-making. The cold truth about workplace violence is that with serious 'what if' planning and diligent application of proactive measures we have the capability of preventing most incidents.

Make no mistake about it, preventing workplace violence is no simple proposition, however, with a comprehensive framework organizations can interrupt the aggression cycle to violence and address many of the known factors that lead to violent outbreaks in the workplace.

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Incivility in higher education: Informing nursing education and practice

Poster

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Focus: Research

Abstract

Background

Incivility in higher education is a growing problem in the U.S. Faculty and students past experiences influence their interactions within the Nursing classroom. A long-term goal is to explore how a commitment to civility in the classroom may extend to a commitment to civility in the workplace. In order to understand the perceptions that contribute to incivility within Nursing education, the present study aims to: 1) document students perceptions of uncivil behaviors in higher education prior to entering two nursing programs in the Midwest; 2) track uncivil behaviors as perceived by students and faculty of the two nursing programs and 3) generate creative strategies to promote civility and address stress in higher education.

Methods

Nursing faculty (n=9) from the Western Campus of the University of Wisconsin, Madison and Nursing faculty and Staff (n=29) from Winona State University completed the Incivility in Higher Education (IHE) scale prior to beginning the 2011-2012 school year. Students (n=24) from Western Campus of the University of Wisconsin and (n=32) from Winona State University completed the IHE scale during orientation to the School of Nursing. Focus groups of faculty and students were held to discuss the data.

Results

Data reported include baseline student and faculty responses to the IHE. Student respondents indicated that incivility was a mild to moderate problem. Students behavior consistently reported as uncivil by students included: holding distracting conversations, cheating, being unprepared, using a computer unrelated to class and creating tension by dominating discussion. Students behavior consistently reported as uncivil by faculty included: demanding make up examinations/extensions, cheating, using cell phones during class and not paying attention. Faculty behaviors perceived as uncivil by both students and faculty included: making rude gestures, being distant and cold, and refusing to answer questions. Both cohorts reported that faculty's failure to address uncivil behaviors as they occur contributes to the problem.

Clinical implications

Faculty and students need foundational skills to address uncivil behaviors and to work together to develop a culture of civility in nursing education. In a culture of civility, faculty strives to empower students and students actively contribute to a civil learning environment. Extending strategies, designed to build a culture of civility in nursing education, to new nurse residency programs may provide another dimension for enhancing a culture of civility in clinical practice.

Learning objectives

1. Attendees will be able to identify the top five uncivil classroom behaviors as perceived by students and faculty.
2. Attendees will be able to list five strategies for developing a culture of civility in the classroom.

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Collaboration is the key: Improving management of aggression exhibited by elder patients through culture change

Workshop

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Focus: Practice
Keywords: Older adults, dementia, responsive behaviors, person-centred care, workplace safety culture, educational development

Introduction

In Canada, just like in the world as a whole, the ageing of the population is projected to accelerate rapidly. By 2026, one Canadian in five will have reached age 65 and correspondingly, the number of Canadians with Alzheimer disease is expected to increase from half a million to one million in the next 25 years (Alzheimer Society of Canada, 2010). Behaviours of an aggressive nature associated with cognitive impairment are common among older persons over 65 years of age who require care across the broader health sector. Older persons with a cognitive impairment often display 'responsive' behaviours such as pacing, kicking and shouting in reaction to over-stimulating and unfamiliar healthcare environments. The current state of practice is that few point-of-care professionals in the health care sector have the necessary knowledge to respond to episodes of responsive behavior of a physical nature that occur at a high rate in institutionalized older adults with dementia. This is significant given that the prevalence of such episodes is reported to be as high as 50% of persons with cognitive impairments living in Long-Term Care (LTC) homes and 98% of geriatric inpatients in some acute care facilities (Buhr & White, 2006; Sourial, Cole & Abrahamowicz, 2001). As a result, there is an increased risk for injury amongst patients and staff. Increasing demands for health services and the changing patient demographics result in the need for more trained and knowledgeable staff to care for older people living with dementia. This workshop will provide participants with an opportunity to dialogue with experts who first developed separate educational programs designed to assist point-of-care staff to manage responsive/aggressive behaviours manifested by older adults with dementia living in facility-based care, then collaborated to align the programs.

Background

The Gentle Persuasive Approaches in Dementia Care (GPA-Basics) is a 7.5 hour, interactive program first developed and evaluated in 2004 and operational based with Advanced Gerontological Education (AGE), in Hamilton, Ontario, Canada. In 2007 a collaborative partnership was developed between AGE and the Public Services Health and Safety Association (PSHSA), also in Ontario, Canada. Collaboration was initiated because the growing body of knowledge related to implementation science (Graham & Logan, 2004) supports that, in order to be effective, educational programs should be designed using knowledge translation principles that will facilitate the shifting of dementia care culture in a positive direction. The key principles include creation of an infrastructure of procedures and practice guidelines that will support theoretically-driven, empirically-tested educational content thus sustaining best practice over time. Recognizing the strength and synergy of their individual programs, representatives from each organization have worked together to align their programs in a variety of ways.

Methods

PSHSA and AGE have combined expertise to create a program that will build capacity and shift organizational culture so that older adults with responsive behaviours are managed with respect and dignity. The critical goal was to work together to satisfy the requirements as legislated in revised workplace legislation and standards of care (Occupational Health & Safety Act of Ontario, 2010; Ontario Long-Term Care Homes Act, 2007) without compromising the strides made in the direction of person-centred dementia care wherein responsive behaviour is interpreted through a theoretical lens of unmet needs (Kitwood, 1997; Kolanowski, Richards & Sullivan, 2002; Kovach, Noonan, Schlidt & Wells, 2005). With this goal in mind, the two organizations partnered to develop a solution-focused, multi-faceted program which addresses expressions of aggression and/or violence in the healthcare sector. PSHSA and AGE each have their unique expertise as it relates to the management of responsive behaviours. PSHSA is a not-for-profit agency that serves Ontario's public service sector through prevention training, risk assessment and safety consulting services, as well as a wide range of training and information products. PSHSA assists organizations in the community and healthcare, municipal, education, and government sectors in achieving safer and healthier work environments. PSHSA has developed and implemented a five step approach to program development in order for facilities to put in place the necessary infrastructure to support and sustain the best practices taught in the GPA-Basics program. AGE is a not-for-profit social enterprise that provides a variety of educational products to complete their mission of *"enhancing the care of older adults by learning together."*

Both PSHSA and AGE have a strong desire to improve the experiences of patients and staff within the healthcare sector. Health and safety of patients and employees are at the forefront of the activities undertaken by these organizations. With this collaboration, additional forces were directed at creating a practical and effective program for the healthcare sector. The aim of the program is not only to educate staff working with elder patients on how to manage responsive behaviours but also to ensure that patients receive the highest level of care while preventing episodes of aggression and/or violence.

Outcomes

The outcomes of this collaborative project indicate that working together on developing solutions and utilizing a multi-faceted approach to issues in healthcare is more effective and efficient than working in silos. Individually, AGE has implemented over 3000 GPA-Basics programs, using over 900 certified, facility-based coaches in more than 600 care facilities in Ontario. Evaluations of GPA-Basics implementation has resulted in outcomes such as 50% reduction in episodes of aggressive behaviour in chronic care facilities (Speziale, Black, Coatsworth-Puspoky, Ross & O'Regan, 2009), reduction in use of physical restraints in all sectors, reduction in Code White episodes and wandering patient episodes in acute care facilities, and increased self-efficacy of point-of-care staff in long-term care facilities. In addition, qualitative outcomes indicate that point-of-care staff can apply the behavioural management strategies in the workplace immediately in a way that maintains the essence of person-centred dementia care (Schindel Martin & Dupuis, 2005).

Specific outcomes of the collaboration between PSHSA and AGE include:
1. Collaborative research initiatives;
2. Direct linkages to each others' websites;
3. Creation of powerpoint and video webcast presentations that are embedded in each others' educational programs (http://www.esao.on.ca/GPA/player.html);
4. Commitment to collaborative advocacy initiatives that will advance best practices associated with responsive behaviours across all health sectors in Ontario, Canada.

Most recently, in March 2011, PSHSA and GPA co-implemented sessions in four distinct regions of Ontario whereby participants acquired PSHSA infrastructure program evaluation tools, then received additional information about the benefits of GPA-Basics training to sustain a culture shift toward person-centred care. The workshops were well attended, and participants found the sessions helpful to acquiring the necessary understandings to develop, implement and evaluate a workplace violence prevention program in their own facilities.

Implications for workshop participants

This presentation will provide an overview of some of the key responsive behaviours that are likely to be experienced by point-of-care providers working with older adults living with dementia across the healthcare sector. It will discuss best practices associated with the assessment of behaviour in the dementia context and the elements involved in making instantaneous decisions about how to manage episodes of responsive behaviour in an appropriate, person-centred fashion.

The workshop will include participation in examples of learning activities and video clips that are used to assist point-of-care staff to shift their values, beliefs and practices in the direction of person-centred care in the context of responsive behaviours. The workshop will include a review of key best practices associated with the Gentle Persuasive Approaches curricula as developed by AGE as well as the tools and infrastructure resources developed by PSHSA to implement a comprehensive program that protects employees and addresses the legislation in the Occupational Health and Safety Act of Ontario (2010).

Acknowledgements

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Learning objectives

1. Identify key responsive behaviours experienced by frontline care providers working with older adults living with dementia and learn about management strategies.
2. Understand best practices and legal obligations of workplace parties related to addressing violence and/or aggression in the workplace.

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Shift Happens: Making the shift to a proactive philosophy and a positive approach

Workshop

George Suess
The Arc of Delaware County, Walton, NY, USA

Focus: Organisational

Abstract

Background and context

In upstate New York, the Arc of Delaware County (Delarc) offers a seemingly impossible counterpoint to the facilities mired in scandal and covered extensively by The New York Times and others during 2011. Delarc is the only such organization in New York State and perhaps nationally - with a written Board of Directors policy prohibiting ANY physical intervention, mechanical or pharmacological restraints. In a determined and concentrated way, this small program is proving that there is another way to approach disability care, one that can achieve far better outcomes than negativity. And one that is readily transferable to other care settings.

Methodology

As described in its best-selling book, Shift HappensMaking the Shift to Proactive Behavior Management, Delarc has integrated the disciplines of psychology, special education and clinical social work into a single model of practice. The secret of Delarcs success is that it has developed progressive human relations practices to support its positive clinical approach. Its recruitment, orientation, training, supervisory, time management and performance review practices have all been designed to support its positive approach. This session will focus on both aspects of its success. It will answer two fundamental questions: what is Shift Happens? And, how do you get people to do it?

Findings

Shift Happens produces unparalleled success for individuals being supported and for those supporting them. Consumers reach their person centered interests at unprecedented rates, abuse has virtually been eliminated and accidents and injuries are so infrequent as to generate insurance and workers compensation rates well below average. Its philosophy and approach are becoming the envy of the field, as was born out in the Dec. 23, 2011 NY Times article which stated, In search of alternative approaches, state officials are now studying the practices of the ARC of Delaware County .

Implications

In addition to the results it produces, another benefit of the Shift Happens Model is that it is easily replicated and produces results quickly. In addition to the work it is currently doing with the NYS Office for People with Developmental Disabilities, during 2008-09 Delarc was contracted by the State of Georgia to help it improve quality and reduce incidents/accidents. One of its customers was the East Central Regional Hospital, Gracewood, Ga. Delarc provided four days of training over a six week period which resulted in an immediate 51% reduction in consumer accident/incidents (from 225 per month to 111). The results were immediate and they held for a full year; at which time the Delarc contract ended. Other Developmental Disability agencies it has worked with include several Arc Chapters in New York State as well as similar agencies in Alaska, California, Louisiana, Illinois, Indiana. Delarc does not advertise. Organizations find it by word of mouth. Therefore most of its customers are within the Developmental Disability community. However, nursing homes and public schools will also find the model appropriate for their settings. How to reach structured 50% participant involvement. This will be accomplished through small group activities and instructional exercises.

Learning objectives

1. 1 To share how an effective model of proactivity and positivity can work to reduce violence and to build a culture of person centered excellence.
2. 2 To illustrate the Human Relations practices needed to support a proactive philosophy and positive approach.

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NO physical intervention for over 30 years

Poster

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Focus: Practice

Abstract

In upstate New York, the Arc of Delaware County (Delarc) offers a seemingly impossible counterpoint to the facilities mired in scandal and covered extensively by The New York Times and others during 2011. Delarc is the only such organization in New York State and perhaps nationally - with a written Board of Directors policy prohibiting ANY physical intervention, mechanical or pharmacological restraints. In a determined and concentrated way, this small program is proving that there is another way to approach disability care, one that can achieve far better outcomes than negativity. And one that is readily transferable to other care settings.

The proposed poster supports this workshop abstract which has been accepted by the conference. It describes the results the Arc of Delaware County, NY has achieved as a result of its person-centered, proactive philosophy and positive approach, which it calls, Shift Happens.

The poster illuminates the unparalleled success of individuals being supported. Individuals reach their person centered interests at unprecedented rates and abuse has virtually been eliminated. Its philosophy and approach are becoming the envy of the field, as was born out in the Dec. 23, 2011 NY Times article which stated, In search of alternative approaches, state officials are now studying the practices of the ARC of Delaware County .

Implications

In addition to the results it produces, another benefit of the Shift Happens Model is that it is easily replicated and produces results quickly. In addition to the work it is currently doing with the NYS Office for People with Developmental Disabilities, during 2008-09 Delarc was contracted by the State of Georgia to help it improve quality and reduce incidents/accidents. One of its customers was the East Central Regional Hospital, Gracewood, Ga. Delarc provided four days of training over a six week period which resulted in an immediate 51% reduction in consumer accident/incidents (from 225 per month to 111). The results were immediate and they held for a full year; at which time the Delarc contract ended.

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Learning objectives

1. To demonstrate that the use of physical intervention is not inevitable.
2. To demonstrate the many benefits of a person-centered, proactive philosophy blended with a positive approach.

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Building a capacity for alternatives: Changing the culture of inpatient psychiatry

Paper

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Focus: Practice
Keywords: Seclusion, restraint, reduction, public health model

Introduction

A review of the literature demonstrates a struggle to reduce the use of seclusion and restraint (S/R) in the treatment of mentally ill individuals for centuries. Published governmental reports and investigative articles have highlighted the dangers of S/R use, including injury and death. The above has resulted in regulation changes and a resurgence of efforts to decrease S/R use. Aggression and violence in the health care sector towards staff has also gained more recognition. Through the use of a Crisis Prevention Management program we were able to change our culture which led to a subsequent 90% reduction in the use of S/R while maintaining a safe environment for staff. This occurred in an 88 bed acute adult inpatient psychiatric service at a large urban teaching hospital.

Method

The public health prevention model, with primary, secondary and tertiary prevention strategies was the framework utilized to change the culture of care. This multifaceted program has its greatest emphasis on primary prevention strategies. The goal of primary prevention is preventing the initial occurrence of the disorder which in this case is the incidence of seclusion and restraint. According to Huckshorn (2004) primary prevention focuses on the development of a clinical treatment environment that decreases the occurrence of conflict and provides early identification and treatment plan for high risk individuals. Key to the implementation was creating excitement and the belief that change could occur in a cadre of staff nurses. Those nurses were the committee that would develop the program and become departmental and unit champions.

In addition to the standardized aggression assessment at time of admission, a personal safety plan was implemented. The admitting nurse and the patient identify triggers, early warning signs of emotional discomfort and current coping strategies.

Environmental changes included shifting staff out of the nurses' station and engaging patients during family style meal. Increasing staff and patient engagement was also achieved through set group and recreational time. Staff left the nurses station for the milieu increasing visibility and interaction.

Staff education propelled a cultural shift; all direct and indirect nursing staff attended an eight hour experiential class to introduce this model. Currently, the yearly training continues to reinforce principles of our program with a focus on prevention and treating the high risk escalating patient. Security personnel are educated with the direct care providers, improving communication and partnering between team members.

The focus of secondary prevention is early identification and intervention for distressed and high risk patients. The components of this program included use of neuro sensory interventions such as a comfort carts, weighted blankets and relaxation room. Plans are created for high risk patients to prevent aggression and staff huddles are held on each shift to improve communication and plan for high risk situations.

Lastly, an extensive tertiary witnessing process was employed to provide a more thorough examination of all S/R incidents used for factor analysis and examination of system issue. Witnessing provides a three hundred sixty degree analysis of the aggressive incident, assists with planning to reduce future episodes for this person and ensures the staff has as appropriate resources.

Results

Hours of data on S/R use were collected throughout implementation and compared with control data. Results demonstrate a 90% reduction of seclusion and restraint between 2004 and 2011 with a decline of 50% beginning in 2006. Statistics, methods of cultural change and tools developed and used by staff will be shared in this presentation.

Conclusion

Utilizing the Public Health Prevention Model is an effective framework for the reduction of S/R. Including clinicians in the development of the program creates empowerment and lasting cultural change. The result is partnering with the patient, increased job satisfaction and safety.

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Learning objectives

1. To describe the elements and tools of primary, secondary, and tertiary prevention strategies as they relate to seclusion and restraint reduction and staff safety
2. To explain how aspects of the Crisis Prevention Management program can be replicated in their organization

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Preventing workplace violence in acute care and long-term care settings through the use of e-tools

Workshop

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Focus: Practice
Keywords: Workplace violence, risk assessment, electronic tools, acute care, long term care, violence prevention

Background

Workplace violence and aggression are serious issues in our health care and community workplaces. Concern is growing about these issues, but it is hard to determine the actual prevalence. Workplace violence tends to be poorly defined and underreported in health care and community service organizations.
Research suggests that violent acts are an increasing threat to the healthcare sector. Acts resulting in physical injury, threats or intimidating behaviour can lead to profound damaging psychological effects, such as loss of morale, confidence and long-term psychological stress.

Occurrence of violence in the healthcare sector is a common issue to many international jurisdictions; countries such as New Zealand, Australia, United Kingdom (UK), Canada and United Sates of America (USA) all report experiences of workplace violence (New Zealand Government, 2009). Violence against healthcare providers is an occupational health and safety issue, and should be managed in the same manner as any other workplace hazard.

Canadian healthcare providers have higher workplace violence incidence rates than other countries with similar models of healthcare (Wang, Hayes, & O'Brien-Pallas, 2008). Occurrences of violence are so prevalent in nursing that the incident rate for the nursing profession has been ranked second only to law enforcement (Duhart, 2001). The Registered Nurses Association of Ontario (RNAO) stated that nurses are three times more likely to experience Workplace violence than any other professional group (RNAO, 2005).

Effective management of workplace violence must be undertaken in the context of the particular workplace environment (New Zealand Government, 2009). It should be managed in a way that takes account of the effect on quality of patient care and staff best practices (New Zealand Government, 2009).
The healthcare staff that are at greater risk for workplace violence include: caregivers, support workers, social workers, security, porters, volunteers, and receptionists (New Zealand Government, 2009). Also, nurses that provide care in emergency area, mental health, geriatrics, and less experienced nurses are at increased risk for workplace violence (Gallant-Roman, 2008; Carmel and Hunter, 1989; Whittington and Wykes, 1994).

Acts of aggression and violence can be committed by anyone. This includes employees, supervisors, managers, clients (patients, residents, customers), students, contract workers, visitors, families of clients, families or friends of employees, or intruders. They can also occur outside of work settings, at work related functions or at off-site locations such as conferences, social events, or client homes visits, or take the form of threatening telephone calls from coworkers, clients or managers.

To help distinguish the sources of workplace violence, we use these four categories:
- Type I (External): Committed by a perpetrator who has no relationship to the workplace,
- Type II (Client or Customer): The perpetrator is a client at the workplace who becomes violent toward a worker or another client,
- Type III (Worker-to-worker): The perpetrator is an employee or past employee of the workplace,
- Type IV (Domestic Violence): The perpetrator usually has a relationship with an employee, e.g., domestic violence in the workplace (California Department of Industrial Relations, 1998).

Consequences from any type of violence can include decrease job performance, satisfaction, morale, increased turnover, and absenteeism (Baltimore et al, 2003). Ultimately violence can lead to poor patient outcome and for the staff health problems such as hypertension, coronary artery disease, depression panic disorder, and post traumatic stress disorder (Sofield & Salmond, 2003; Bussing & Hoge, 2004).

In December 2008, St. Michael's Hospital (SMH) made a corporate commitment to implement the RNAO Healthy Work Environment Best Practice Guideline Preventing and Managing Violence in the Workplace (RNAO 2008). As a result of this commitment, SMH contacted the Ontario Safety Association for Community & Healthcare (OSACH) to assist them in the development of an electronic Workplace Violence Risk Assessment Tool (WVRAT), a project funded by the Ministry of Health and Long Term Care (MOHLTC).

For Ontario workplaces that are subject to the Occupational Health and Safety Act, a risk assessment for workplace violence is required (effective as of June 15, 2010). As a result of this change in legislation, PSHSA applied for and received funding from the MOHLTC in 2012 to develop an electronic version of the SMH tool

that could be used by all hospitals in the province, and further funding to develop a similar tool for long term care homes.

Main Paper/ article

Research has shown that risk assessment is the first building block of any effective workplace violence prevention program (Wang, Hayes, & O'Brien-Pallas 2008). In order to establish a comprehensive prevention program, health care organizations must be equipped with a comprehensive, evidence-based risk assessment tool to determine the risk of potential and actual violence in the workplace.

Research indicates senior management commitment is needed to achieve program excellence in health and safety (Stewart, 1999).
Employees need to be assured of their safety and have trust in leadership's commitment to ensure an emergency response mechanism that focuses on providing assistance to staff (Braverman, 2003).
Employers must assess risks associated with workplace violence. This includes an assessment of community workplace violence issues; internal documents; the organization's physical environment; the work setting and clients; point-of-care work practices; and staff perceptions (OSACH, 2006).

A workplace violence prevention committee was struck in 2007 at St. Michael's Hospital, Toronto, Ontario. This committee was charged with the responsibility to assess the risk for workplace violence and develop/ implement a number of policies and procedures related to violence prevention.
A second committee, the Workplace Violence Risk Assessment Tool (WVRAT) Steering Committee was struck in March of 2009, to develop and implement the WVRAT.

SMH contracted PSHSA to assist them in the development of an evidence-informed, web-based, user-friendly assessment tool. PSHSA completed a literature review of workplace violence in healthcare organizations and the tools currently available to assess and control these risks (see acute care resource list). From this data, a tool was developed for SMH specifically intended for use in acute care settings, to identify and assess risks associated with workplace violence and to select appropriate controls to manage these risks. PSHSA continued to work with the SMH steering committee to refine the tool and control measures. The tool was divided into three sections to reflect the various risk factors outlined in the literature. These sections are: 1) the physical environment, 2) work settings, and 3) clinical practices. Each section was further broken down into hazard categories. Controls and solutions for these hazards were assigned based on degree of risk. Ranking or prioritizing the risk factors is one way to help determine which safety hazards are most serious so they can be addressed first. Priority is usually identified by taking into account how much or how often a worker is exposed to the situation or conditions, and the potential for harm. The risk assessment scale and matrix help to determine the degree of risk for all four types of workplace violence, based on SMH risk management program and a review of occupational health and safety risk scales.

Three higher risk pilot units were identified to trial the tool. Department managers, Joint Health and Safety Committee members and security staff completed the tool for the pilot. A four hour educational workshop was provided to key stakeholders and subject matter experts across SMH for the purpose of tool design and feedback. A subgroup of the SMH project steering committee with representatives from Corporate Health and Safety Services and Security focused on providing feedback to the draft tool. Two areas consistently identified as high risk (and supported by the literature) were:

- Working directly with public
- Working with high risk patients who may exhibit aggressive responsive behaviour associated with their condition.

Approximately, 80% of the pilot users agreed that the e-tool was easy to use. Following a successful pilot, the tool was rolled out to all 50 departments at SMH.

Two innovative features of the tool are risk assessment and action monitoring capabilities. Clinical Leaders/ Managers will be able to conduct their unit assessments and generate potential solutions for each hazard identified from the risk assessment. The potential solutions are categorized as short, medium or long term. The manager can assign action items to the most appropriate person at their organization and track and determine solution completion dates for their action items.
The tool can also generate aggregate reports and individual unit reports for ease of use.
A rigorous evaluation is in progress at SMH to evaluate the impact of WVRAT implementation on provider outcomes.

Conclusions

Based on the early success of the SMH project, and changes to the OHSA in Ontario that required all workplaces to complete a risk assessment for workplace violence, PSHSA has made slight revisions to the tool and made it available to all hospitals in Ontario through their website. In addition, a literature review was completed for risk factors and tools in the long term care sector and a similar tool developed for use in Nursing Homes in Ontario (see long term care resource list). This tool is also available on the PSHSA website.

Acknowledgements

St. Michael's Hospital Workplace Violence Risk Assessment Tool (WVRAT) Steering Committee
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Learning objectives

1. Identify effective strategies aimed at protecting healthcare employees from workplace violence and aggression.
2. Become familiar with a number of e-tools and resources available to address and prevent workplace violence and aggression in healthcare settings.

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A violence prevention program from theory to sustainability

Paper

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Focus: Practice

Abstract

Implementation of the Violence Prevention Program (VPP) in Interior Health, located in the Province of British Columbia in Canada, resulted from the 2006 collective bargaining language, as well as the employers ongoing obligation to comply with Occupational Health & Safety (OHS) Regulation Section R4.29-2 (Workplace Violence Prevention Program). The collective bargaining process allowed health authorities to strategize delivery of an all-inclusive program whereby all elements of the OHS regulation would be effectively operational within all levels of the organization.

The VPP includes many different infrastructure pieces to support the safety of staff, patients and others. This includes training, information sessions, aggressive behaviour alerts, aggressive behaviour assessments, standardized processes and documents, advance restraint documentation for acute care, communication with internal and external partners, code white response plans, policies, code white reporting, development of VPP site committees, etc. It is all these pieces that will take the program from theory to sustainability, embedding itself into a culture of healthcare which embraces the health and safety of all who are a part of it.

In the Winter of 2008 violence prevention training was initially offered to an acute care facility, Penticton Regional Hospital (PRH) located within the Okanagan health services area. With the support of the site administrator a site lead was identified and a VPP site committee was developed. With these dedicated resources the PRH VPP was established and sustainability began. Prior to this time all that was offered at PRH was violence prevention training which was not healthcare specific and was not supported with any infrastructure so it had limited success.

Since that time this site has developed a site Code White response plan, identified two site trainers, implemented the Aggressive Behaviour Scale & the Aggressive Alert process, maintained the site Code White data collection spreadsheet and built relationships with key partners e.g. security and police.

Over the past 3 years the VPP at PRH has grown well beyond what the initial expectations of where the program would be. It will be demonstrated that since the VPPs has started at PRH there has been a significant increase in the number of Code White incidents reported but a reduction in the number of physical interventions. Therefore we can surmise that the VPP is better equipping PRH in deescalating the patient through the emotional or behavioural crisis and the staff are not getting injured emotionally or physically as often. Also there has been a reduction in the overall cost of aggressive/violent incident related WorkSafe BC claims. It is assumed that the enhanced VPP has contributed to this cost reduction.

The VPP at PRH is guided by the following vision. Adopt a Safety for All philosophy whereby the work environment becomes the common space that is shared by all (workers, clients, public, BCAS and RCMP) and that this space is occupied within a spirit of mutual respect towards violence prevention.

Learning objectives

1. A violence prevention program needs to include more infastructure components than education and training.
2. A successful violence prevention program needs to include support from all levels of the organization.

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Developing a healthy workplace model for registered nurses

Poster

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Focus: Organisational

Abstract

Introduction

Increasingly higher levels of burnout and job dissatisfaction for RNs (registered nurses), frequently associated with horizontal violence, bullying and turnover, are present throughout Canada, the US, and elsewhere. Canadian researchers developed a tool to identify the unique experience of individuals who are passionate about and energized by their work, also known as spirit at work (SAW). Identification and acknowledgement of the organizational characteristics that support individual RNs to experience SAW assists with the development of superior care environments. These environments are linked to higher quality nurse outcomes, including reduction of horizontal violence or bullying, and the associated improvement in the quality and safety of patient care.
This study: (a) identifies what RNs perceive as contributing to their personal SAW in the workplace; and (b) develops and tests a theoretical model of the relationships among resonant leadership, structural empowerment concepts, psychological empowerment concepts, SAW concepts, the demographic variables of experience, education, and rank, and the outcome variables of job satisfaction and organizational commitment.

Method

This survey consists of six questionnaires previously tested for reliability and validity. We used an explanatory cross-sectional, multimodal design of postal and web-based surveys. Four hundred sixty seven randomly selected RNs, stratified according to place of residence--urban or rural Alberta, received a postal invitation and survey from the provincial professional association. Comparison of the demographics of the 144 RN responses to the provincial demographics indicated: a significantly greater number of RNs in management for the survey sample than in the provincial data ($chi^2 = 17.71$, $p < 0.001$); and a significantly larger proportion of RNs with masters or doctoral preparation than diploma ($chi^2 = 15.41$, $p < 0.001$) or baccalaureate ($chi^2 = 16.87$, $p < 0.001$). Chi square analysis indicated no significant differences for work location or age. We used LISREL 8.80 (Jöreskog & Sörbom, 1996) to test the theoretical model of relationships.

Results

A non-significant chi-square (chi-square=56.22, df=56, p=0.466) indicated that the model's predicted value fit the observed data. SAW is a desirable workplace outcome leading to organizational commitment for RNs. Analysis of the responses to the single open-ended question painted a picture of the important relationships leading to SAW.

Conclusions/Significance

SAW is an outcome of resonant leadership, structural empowerment and psychological empowerment while also leading to organizational commitment for this sample population. Utilization of results from this research will contribute to a healthier environment with reduced horizontal violence, bullying and turnover for RNs and improved quality of care for patients.

Learning objectives

1. The presence of resonant leadership, employee support, opportunity, appropriate resources and information (structural empowerment concepts) leads to increased individual RN perceptions of engaging work, sense of community, spiritual connection, mystical experience (spirit at work concepts), and organizational commitment. Previous research indicates that healthier RN workplaces lead to improved patient outcomes.
2. Spirit at Work is an important workplace outcome that is composed of engaging work, sense of community, spiritual connection and mystical experience.

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Perspectives' of Critical Care Nurses on Workplace Violence

Poster

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Focus: Practice
Keywords: Violence; workplace, critical care nurse, hospital management

Abstract

Introduction

Security is of the most important aspects of occupational safety and health and workplace violence and threats have shown as one of the occupational problems that followed by bad effects. Nurses as the most high risk persons to workplace violence, are very interested in eliminating the violence because of it seems very difficult to provide safe and high quality care in an indelicate environment and have a good job satisfaction and morale at the same time.

Purpose

The aim is to overview the Workplace Violence from Educational Hospital's Critical Care Nurses Perspective of Hamadan Medical University and offer a workplace violence management policy

Method

A descriptive analytical study was took place in 2010 on the critical nurses and managers who were hired in Hamadan medical university hospitals. 170 nurses were surveyed by using of random classified sampling. Using the descriptive statistics, data was analyzed with SPSS16 statistical software. Using the purposeful sampling till data saturation, 23 managers were participated in interviews and then, qualitative content analysis was performed.

Result

Total violence prevalence was 74/1% and the most happened violence were verbal abuse, threat, physical assault and sexual harassment respectively. The most providers were patients and their relatives. Verbal reporting often used by nurses and legal pursuit was less occurred because of the sense of wasteful reporting. The most of nurses didn't satisfy with violence management in their institution.

Discussion

Despite of high violence prevalence, written report and legal pursuit is low. May be by the Nurses' education, managers' support, supervision on presence of patients' relatives in the ward, security reinforcement and effective interpersonal communication, we will achieve to reduce the violence's rate.

Learning objectives

1. To share contextual atmoshear of workplace violence in Iraian Nursing practice
2. To get reflections of the conference attendences

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Chapter 14 - The minimisation/ reduction of seclusion, restraint and coercive measures

An intervention to reduce seclusion on an inpatient intensive care psychiatry ward

Paper

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Focus: Research

Abstract

Hypothesis

Training of staff on the PY3-S inpatient unit in the Core Strategies program and the subsequent implementation of those techniques will result in a lower incidence of seclusion.

Background

Seclusion is a psychiatric practice that can have negative outcomes for both staff and patients. There have been several methods described with potential to reduce seclusion but there is no gold standard. One promising intervention, the Core Strategies program, will be implemented on a psychiatric intensive care ward.

Method

Following staff training in the program, data on seclusion incidence and duration, as well as the secondary outcomes patient aggression, staff injury and medication usage will be collected. Data will be evaluated at 12 and 24 months. Comparison with pre-intervention seclusion rates on PY3-S and another inpatient ward utilizing practice as usual will determine hypothesis validity.

Results

12 month data will be available in April 2012 but preliminary results show a significant decrease in both seclusion incidence and duration.

Conclusion

The Core Strategies program appears to be effective at lowering seclusion usage in an inpatient population that has historically seen high rates of seclusion.

Learning objectives

1. Have a basic understanding of a strategy for reducing the use of seclusion on an inpatient psychiatry unit.
2. Have an understanding of the rate of reduction of seclusion incidence and duration during the first year a new strategy was implemented.

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Psychiatric intensive care unit: Two profiles positively associated to seclusion and restraint

Poster

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Focus: Research

Abstract

Background and context

The main reasons for admission to a psychiatric intensive care unit (PICU) are aggression management or and high-risk behavior (Le Bihan et al., 2009). In this context, aggressive behavior sometimes leads to coercive measures such as seclusion with or without restraint (SR) which is more frequent on in PICU than on in general acute wards (Bowers et al., 2008). A better understanding of psychiatric patients' characteristics would guide a discussion on alternatives to seclusion that would be more consistent with patient characteristics. According to our knowledge, no study has been interested yet in the relationships between different characteristics of the patients placed in seclusion, especially not in a PICU. The aim of this study was to identify and describe profiles of patients admitted to a psychiatric intensive care unit in relation to seclusion and restraint.

Methodology:

Multiple correspondence analysis (MCA) and cluster analysis were performed on 114 patients admitted to a psychiatric intensive care unit from June 8, 2010 to June 7, 2011.

Findings

The MCA yield four dimensions that explain 58.6% of the Greenacre adjusted inertia. Clustering leads to five profiles of which two are significantly associated with SR: young psychotic men and bipolar women. This last profile is little discussed in literature.

Implications for practice and research

These results lead to a better understanding of the characteristics of PICU patients by health professionals. They raise questions regarding the treatment of men and women based on their diagnosis. The development of interventions for the reduction of SR in PICU should reflect the different patient profiles and be better adapted to PICU patients' needs.

Learning objectives

1. Participants will learn that two profiles were positively associated to SR in a PICU: young psychotic men and bipolar women.
2. Participants will learn that these results lead to a better understanding of the characteristics of PICU patients by health professionals.

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Releasing the mentally ill from physical restraint: An experience from a developing country

Paper

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Focus: Practice
Keywords: Restraint, seclusion, mental illness, tsunami, Aceh

Introduction

Applying physical restraint to people with a mental problem is a common practice in Indonesia. A locally well known term; «pasung» refers to an action to restrain, to confine the mentally ill in such a place to minimize or restrict their movement, which mostly happen in the community. This pasung can be done either by chaining the legs or arm, locking the patient in a room and even in the pigpen or goat shed. It is estimated that there are more than 30.000 of people with a mental problem being restrained in the country, where about 200 of them were found in Aceh.

Realizing the burden of this inhumane treatment; the government of Aceh initiated a program called *"Aceh Free Pasung"* in early 2010, aiming to release all patients from the confinement. This program includes building a new ward in Aceh Mental Hospital and forming special teams from hospital staffs. Their task was to release the patient from pasung and to bring them to the hospital for proper treatment.
To the date, the program has not only met it goal to provide freedom to this vulnerable group but also has proven that minimizing the violence in mental health care can be implemented even in low resource settings. This paper is a supplement to the previous report (1) with new updated information to the issue, and further discussion of the factors that constitute the successful of the program.

Aceh And Mental Health Burden

Aceh is a special region in Indonesia with 4,5 million population. The province was heavily hit by the earthquake and devastating Tsunami on Boxing day 2004, causing more than 236.000 deaths, about 514.000 homeless and more than 1.000 of children lost their parent. Before the tsunami, the Acehnese had suffered with 29 years of military conflict between the Indonesian army and GAM (Aceh Freedom Movement) causing thousand of civilians death and missing, homelessness and the demolition of economic condition of the society.
Mental health in Aceh once considered as the worst in the country. The military conflict provokes the insecurity of daily life condition, causing the proper mental health care could not delivered properly. Scarcity of skilled human resource, poor health care facility and equipment, poor of drug supply, as well as poor literacy of the community towards mental illness, all together, causing the hight prevalence of mental case in the region. The report from basic health survey conducted in 2007 suggests that about 14,1% of Acehnese population has experienced with a mental problem, higher than that mean of national prevalence (11,4%). In some districts, the prevalence account to 30% of the population (2). This suggest that mental health was an emerging situation in the province.

Before the tsunami, there were only three physiatrics worked in the province, one mental hospital with 280 beds, were hardly any nurse trained in mental health care and the psychiatric drugs mostly available in the psychiatric hospital. The condition is much better recently; there are about eleven psychiatrists working in the province, more than 600 community nurses have been trained in mental health care, and had the old psychiatric hospital renovated. Although this new hospital increases the service capacity, the occupation rate is always more than 200%. Table 1 shows the comparison of mental health care in the province.

Table 1 Comparison of mental health service in Aceh; before and after the tsunami

Mental health services	Before Tsunami (2004)	Recently (2012)
Number of psychiatrists	3	11
Number of mental health nurses	Hardly any	More than 600
Availability of essential psychiatric medicine in health post	Very rare	Almost available in every health post
(Local) government concern on mental health	Hardly any	Much better
Payment system	Mostly out of pocket	Universal Health Coverage

Devastating earthquake and tsunami in 2004 play significant role to enhance the improvement of community health status in the province. The disaster acts as the catalyst towards the betterment of health care, including mental health services. It was able to attract international community's attention to assist and provide required aids after the calamities. It was also able to convince the government upon the significant of the problem which

consequently change the health care service to meet the demand and needs of the community. Among the most feasible government program was to deal with the chronic, misbehave, and inhumane treatment of the community towards people with mental illness; pasung.

Aceh Free Pasung Program

The Aceh Free Pasung program was obviously not such an advanced or sophisticated program; it was simply releasing the mentally ills from pasung, brings them to the hospital, treat them properly and sends them back to the community when they are clinically well. However, there are factors behind and consequents from this program that makes it special. This was the first program in Indonesia that release people from pasung in a quite large number. Success of this programme also inspires the Indonesian central government and other provinces in the country to initiate the similar programme. The Indonesian government later launched a program called Indonesia free Pasung by 2014. Other provinces and districts have also initiated to release the mentally ills from pasung.

Results from the previous study (1) suggest some reasons for applying pasung such as amok or aggressive behavior, concern of the family about the patient's safety, wandering and financial problem that the family could not afford to pay for the hospitalization. Poor literacy of the family and the community towards the diseases is another reason that significantly influences pasung decision. There are beliefs that supernatural factors cause mental illness and therefore, only can be treated by religious or traditional healers. Consequently the help seeking behavior of psychiatric problem of the community to the health professional were low (3), and pasung becomes the last choice when other options cannot be carried out.

Table 2: common reasons for applying pasung

Nr	Reasons for applying pasung
1	Financial problem
2	Wrong belief about the cause of mental illness
3	To prevent patient from aggressive behavior
4	To prevent wandering, violence and abused
5	"No one look after the patient while the family are working"
6	"Expression of love" and to prevent bullying
7	Last option when other treatment was not possible

The study also confirms that the mean duration of patient in pasung were four years, with the longest case found was 20 years. About one-thirds of them found to have atrophy in their leg or arm, mostly due to the longtime fixation. Furthermore, most of the previously pasung patients were diagnosed with schizophrenia. After releasing from pasung and bringing them to the psychiatric hospital, the majority of the patients were covered with social health insurance, either by the local (JKA) or national based health insurance (Jamkesmas). Discussion from this study also suggests that elimination of pasung practice requires the development of adequate and accessible social support and community based mental health services as well as community education on mental health (1).

Factors to the improvement of mental health care in Aceh
The lancet series on mental health 2007 exclusively discusses the barriers to the improvement of mental health care in low and middle income countries. The barriers include insufficient funding for mental health service, low political will, centralization of mental health resources, difficulties in integrating mental health care in PHC, poor human resource capacity, and mental health leadership often lacks public health skills (4). The situation was much likely found in Aceh, thus various programs were proposed to overcome the barriers.
Mental health improvement program in Aceh obviously was not designed based on the highly scientific assessment and with comprehensive planning, but rather an accumulation of various programs that initially not related. However later they able to support each other.

After the tsunami in 2004, the demand and need for emergency aids from the survivors was extremely high. The national and international communities responded it with tremendous helps to reduce the suffering of the victims. Thousand tons of medicines and equipments were shipped to the affected region, destroyed health facilities were rebuilt, the health care providers were trained, and awareness raising campaign on health issue to the community were conducted, all of wich contributes to the betterment of health status of the Acehnese.
The availability of external aids was a fundamental factor to the development of mental health care in the region. The aids was not merely on financial support but also skill and knowledge sharing between the local staffs and the national and foreign volunteers. Many NGOs introduced new concepts of mental health care, provide the health care workers with trainings as well building new health care facilities. These aids were important to the betterment of health service in Aceh.

With a large wave of trainings conducted, the human resource were improved. These new skilled health staffs were not only able to replace their colleagues who passed away in the disaster, but also able perform better and provide better quality of health care. Among the most well known program was the training of more than 500

community mental health nurses or CMHN. This brought Aceh to have the largest mental health nurse ratio in Indonesia. Most of these nurses work in community health center (puskesmas), which works directly with the mentally ills in the community. They do the regular visit to the patient's home, educate the patient and provide the medicine. They also work as the pasung case finder in the community and will be the person in charge after the patient treated in the hospital and sends back to the family. This continuos chain enables the person with mental illness to obtain proper treatment and medication.

Another historic moment following the tsunami was the achievement of the peace agreement between the Indonesian government and GAM. The memorandum of understanding was signed in Helsinki on August 15, 2005 facilitated and witnessed by former Finland president and later Nobel peace price laureate Mr Marti Ahtisaari. For both parties, this agreement was a turning point to cease conflict and violence and start building the province from the ruins.

Following the agreement, the government of Aceh introduced a new health care payment system called JKA or Aceh Health Insurance. This social health insurance aims to cover the poor in the province that were not covered in the existing national based insurance, jamkesmas. In this system, all of Acehnese who do not have health insurance have right apply and be the member. The premium, which is about Rp. 17.000 (about 1,5 euro) per each insure, is paid by the government. The JKA was launched on first of June 2010 has now covered more than one million population.

Table 3: Factors enabling the improvement of mental health service in Aceh

- External aids
- Good human resource (Availability of CMH in almost each health post)
- Availability of essential medicine
- Mental health care is integrated in PHC
- Strong local government commitment
- Universal health coverage through JKA
- Deman and acceptance in the community

Another fundamental issue that ensure the succes of this program is the acceptance in the community. The community mental health nurses argue that sometimes it was terribly difficult at the beginning to convince the family and the community on treatment with western medication system. The poor literacy and wrong perception on mental illness causation, as well as stigma in the community, enforce the health worker to double the effort in educating and explaining them to the right path. After several meetings, the community gave their agreement to the health staff and even support this program.

Lesson learned

Just like other top-down Government programs, Aceh Free Pasung also started with pessimism among the health worker and community. But as time passed, the program was able to reach the goal and obtain the appreciation. Many lessons can be learn from this program; that peace is the most fundamental prerequisite to start implement any health program, that releasing the people with mental illness can be implemented when there is strong concern from the government, the health care staff and that essential medicine is available in the nearest place to the patient and affordable for them. Finally, in order to enhance the mental health care in the low and middle income country, a global solidarity is needed.

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Learning objectives

1. Minimizing physical restraint and violence towards people with mental illness is possible in poor resource setting.

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A conceptual model for nurses decision making with the aggressive psychiatric patient

Paper

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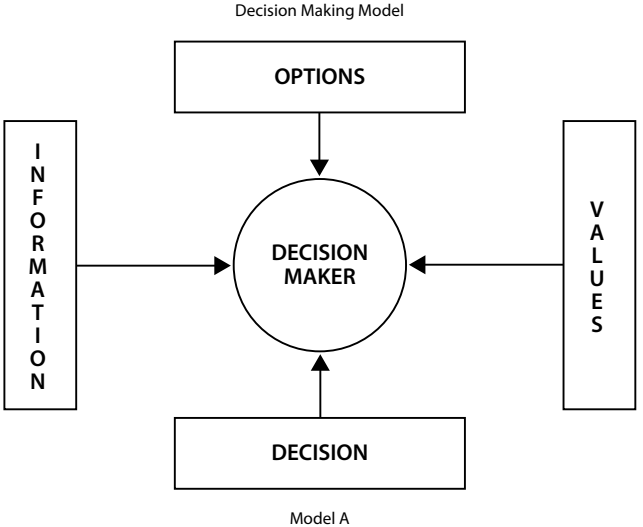
Focus: Research
Keywords: Decision making model, nursing, patient aggression, psychiatry, violence

Introduction

Maintenance of a safe therapeutic environment in acute care psychiatry is of paramount concern. In order to support therapeutic and safe patient outcomes, there has been an effort to reduce and, ideally, eliminate the use of physical restraints (APNA, 2007; Paterson & Duxbury 2007). Yet, aggressive behavior on the part of patients in acute care psychiatric settings is endemic and may in fact be increasing (Duxbury & Wittington, 2005; Paterson & Duxbury 2007). When aggressive, assaultive or other potentially dangerous behavior does arise in an acute care setting, it is the nurse's ethical and professional responsibility to intervene in the least restrictive therapeutic approach which also maintains safety (ANA, 2005). This responsibility includes ensuring the safety of the aggressive patient who may be attempting self harm, the safety of health care providers and the safety of all others who may be present. In order for the nurse to best provide compassionate therapeutic care to the aggressive patient as well as maintain safety, it is imperative that the nurse utilize good judgment, based on critical thinking, in choosing the appropriate interventions which will achieve the desired goals identified above.

Since nurses are required to make decisions on interventions with aggressive patients as quickly as possible and under stressful conditions, it can be helpful to examine, from a theoretical perspective, how these decisions can be made effectively. To do this successfully, it is helpful to gain understanding of how nurses make decisions in the presence of patient aggression. Factors that influence the nurses' decision making need to be identified and relationships between these factors need to be understood. A preliminary model of nurses' decision making with aggressive patients was developed using theoretical concepts identified in the literature. It was tested in a study conducted by the author in a study reported in 1996 and modified in response to the study (Moylan, 1996). Findings from recent quantitative and qualitative research studies (Moylan & Cullinan, 2011)conducted by the developer of the model and from ongoing review of the literature add support to the model. The following is a description of the model.

In developing the model for nurses' decision making with the aggressive patient, a general model for decision making was identified in the literature. This general model for decision making was developed by the Committee on Evaluation PDK National Study (Stufflebeam et al, 1971) and is still used in education today. It was selected as the basis for the Nurses' Decision Making with the Aggressive Patient model because of its simplicity and its ability to be applied to clinical situations. The general model identifies three factors which influence decision making. These are: options, information and values.



Model A

The following is a description of the development of the Nurses' Decision Making Model using the basic concepts from the general decision making model.

Options

In the nurses' decision making model, available options are based upon good clinical practice utilizing available evidence relating to the achievement of therapeutic and safe outcomes and consistent with legal requirements related to least restrictive interventions. These include therapeutic approaches which include verbal and non-verbal communication, modification of the environment and offering P.R.N. medication if this has been ordered. If these approaches are ineffective, and escalation of aggression has reached a level of immediate danger to self or others, seclusion or restraint, in conjunction with medication administered against the patient's will, may be indicated.

Information

In analyzing qualitative data from the above studies and information in the literature, mediating factors were identified which impact upon the nurse's perception and interpretation of an aggressive incident. Consequently, in this model, the factor labeled *"Information"* in the general decision making model by Stufflebeam et al. (1971) has been changed to *"Perceived Information"*. Perceived information is impacted by professional knowledge, experience and emotional responses (conscious and unconscious) to the aggression. Professional knowledge encompasses formal education and training as well as knowledge of law and policy in relation aggressive behavior. These aspects consist of concepts which encompass objective standards. Clinical experience, on the other hand, may include both objective and subjective components. Observations of therapeutic approaches which are effective or ineffective can be tested and measured and consequently have some degree of objectivity. But prior experience with assault by a patient can negatively impact a nurse's ability to be objective when experiencing a threatening incident in the presence of patient aggression. My research (Moylan, 1996; Moylan & Cullinan, 2011) has demonstrated that nurses report strong emotional responses that include fear, emotional freezing, anger, feelings of impotence and insecurity in the presence of serious escalating patient aggression and violence. Such emotional responses can impact the perception of an aggressive event.

Values

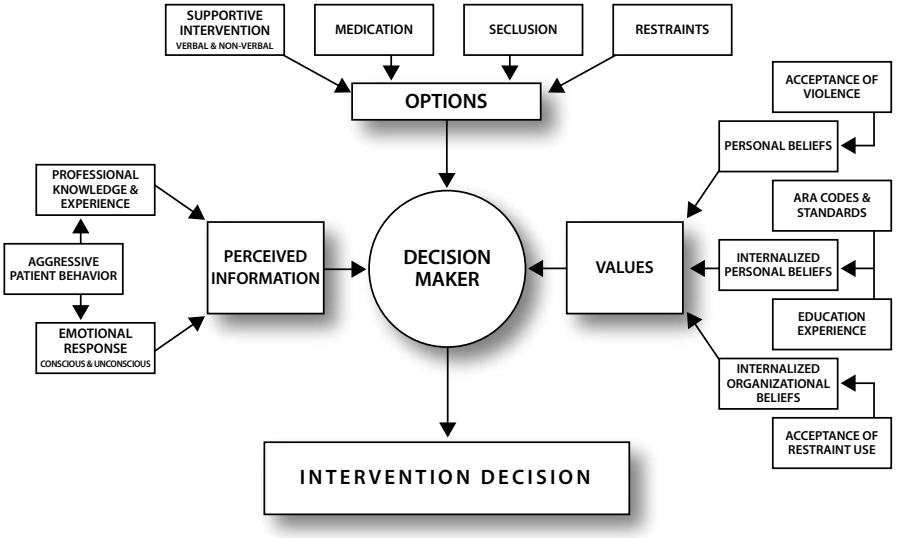
The development of a nurse's value system can be conceptualized as arising from the sub-components of personal beliefs (Nolan, Haque, Bourke & Dyke, 2004), professional beliefs (Weis & Schank, 2002) and organizational beliefs (Schiff, 2009). Each of these, in turn, is impacted by other factors resulting in a complex interaction of cognitive and psychosocial dynamics. Specifically, in our society today, there exists a culture of violence. This can be seen in the availability of violent video games available to children, the frequency of bullying which occurs in the school yard and the boardroom, and in increasing domestic violence. These factors can result in a great disparity in nurses' acceptance of violence in their own personal belief system. Professional beliefs also contribute to the values of the nurse. Educational experiences, as well, play a role in informing nurses' overall value set in relation to their general belief system and how this affects their professional practice.

The American Nurses Association developed a Code for Nurses (2005) which clearly elucidates the nurse's professional responsibility in providing safe and ethical care to patients. In the United States, this is an integral part of nursing education and contributes to the nurse's development of professional identity and value set. Professional standards, when accepted by the individual as having validity and worth and are practiced over time, become internalized and automatic. Internalized professional beliefs are something that nurses bring with them to all decision-making in practice. Organizational belief is also a significant influence in shaping values in health care settings (Johnson, 2009).

The belief of what is important to an organization in encompassed in that organization's culture (Hellrigel & Slocum, 2010). The culture of an organization will affect its explicit behaviors, such as formal policy, and its implicit norms, such as the interpretation of how policy is carried out. As the goal of more humanistic care of the mentally ill is being recognized internationally (Huckshorn & LeBel, 2007)), health care organizations are stressing the need for the most therapeutic and least restrictive response to the aggressive patient. Education and training of staff in appropriate interventions contribute to the nurse's valuing of this approach. Although there has been resistance to some of the least restrictive policies (Curran, 2007), organizations have reported significant decrease in restrictive interventions as nurses become more accepting of this approach (Moylan & Cullinan, 2011).

From the above information concerning the complex relationship between multiple factors, the following model of nurses' decision-making with the aggressive patient was developed.

Moylan's Model for Nurses' Decision Making with the Aggressive Patient



Conclusion

Accurate and effective decision making with aggressive patients is imperative if a safe and therapeutic outcome is to be achieved. This paper describes the development of a decision making model based on a general decision making model which was modified for application to aggressive behaviors events in the psychiatric setting. Modifications to the general model were derived from discussion in the professional literature related to management of aggression and from prior studies conducted by the author. The significance of this model is that it can be applied in the development of effective teaching and training programs by addressing specific areas recognized as impacting decision making. When considering the multiple factors that impact the nurse's decision making with an aggressive patient, it is important to address both the factual components, such as therapeutic communication skills etc, and the affective components of emotional responses and values. Further research and testing of the model is recommended. Modifications of the model depending on outcomes of further study may be indicated.

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Learning objectives

1. The learner will identify factors that influence nurses' decision making with aggressive patients.
2. The learner will become better able to effectively intervene with the aggressive patient.

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Partner violence and its consequences on women attending primary health care and ante natal centers in South West Nigeria

Poster

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Focus: Research

Abstract

Violence within intimate relationship is a significant problem all over the world which adversely affects the health and safety of thousands of women throughout their lifespan. This study therefore described the various pattern of abuse suffered by women and the possible health risks which undeniably would contribute to affecting their total wellbeing.

The study involved 444 respondents aged between 15 and 49 years, who visited six primary health care centers in Ibadan. These women were currently or had been engaged in an intimate relationship prior to the study. A systematic sampling technique was used for selection of respondents apparently visiting primary health care centers. The respondents were registered and given clinic card with identification number. Hence every third woman who visited was selected until 444 respondents were recruited.

The mean age of respondents was 26years and their intimate partners were 33 years. About 81% of the respondents were married while 19% of them either cohabit with their male friends or have sexual relationship. 54.5% of the respondents claimed they had completed their secondary school education while 64% of their intimate partners had same educational background. Perhaps this may explain why the majority of women and their spouses or (boyfriends) were found to belong to social classes 4 and 5. Thus, 20.7% of the women are artisans and 61.9% of them are petty traders. Likewise the men on the other hand are mostly artisans, constituting about 46% while 35.6% of them were either labourers or messengers. The major religion practiced by residents of the study area is Islam; hence the study revealed that about 84% of the women are Moslems while those who practiced Christianity are about 16%. About 77% of the women had at least a child for their partner. Most of the respondents (75. 1%) posited that their marriage was a monogamous type while 20% revealed that their partners had at least one wife apart from them. Awareness of intimate partner violence was considerably high with 73% of respondents able to identify or give an example of IPV. Interestingly, 76% of women identified slapping, hitting and beating a woman as acts of physical violence, while 71.6% of the women were also able to identify various forms sexual abuse.

The incidence of intimate partner violence persisted in Nigeria and women were more likely to be inflected injury as acts of physical violence by men. More often than not, they are most likely to suffer sexual abuse in the hands of a male partner. Therefore, governments at all levels and Women Advocacy Groups and other International Organizations dedicated to reducing violence against women should take a proactive action against perpetrators of this crime against women.

Learning objectives

1. Participants will gain knowledge regarding the pattern and prevalence of intimate partner violence.
2. Participants will gain knowledge regarding associated risk factors among women attending primary health care centers in Nigeria.

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A multidimensional approach in restraint minimization: The journey of a mental health organization

Workshop

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Focus: Organisational
Keywords: Restraint minimization, recovery, therapeutic relationship, mental health

Introduction

Ontario Shores Centre for Mental Health Sciences (Ontario Shores) is dedicated to restraint (mechanical, chemical and seclusion) minimization to promote a recovery-oriented approach to care and ensure staff and patient safety. This commitment promotes reducing the frequency and duration of the use of restraints and increasing the use of alternative interventions. The utilization of restraints and seclusion is only supported as a last resort when all other alternative interventions have been exhausted and there is a presence of imminent risk.

While institutional methods of control, such as seclusion and restraints, may seem warranted at times, there is growing literature indicating the potential counter-therapeutic effects of these practices (Borckardt et al., 2011). Evidence has linked restraints and seclusion to a number of adverse outcomes, such as further exacerbation of aggression, injury to staff or clients, increased costs, re-traumatization, and rupture of the therapeutic alliances amongst the staff and clients (Ashcraft & Anthony, 2008).

The Organization's recovery-oriented model of care places emphasis on collaboration with patients and families to implement a preventative approach towards care. The goal is the early identification of alternative interventions for patients who may be at risk of restraint use and proactive implementation of a management plan to help mitigate the use of restraints while strengthening the therapeutic alliance and empowering patients in their care.

Background

Historically mental health care has focused on a biomedical, paternalistic approach in managing therapeutic relationships with patients. Incidents of patient aggression and violence are common occurrences in inpatient mental health settings (Duxbury, Bjorkdahl and Johnson, 2006; Duxbury and Whittington, 2005). Increasing evidence within literature supports the development of multidimensional models for the management of violence and aggression in such settings (Duxbury, 2002). In recent years, there has been a shift to a more proactive patient-centred recovery-oriented approach to care with a focus on reducing aggression and violence. To promote quality patient care and staff and patient safety, Ontario Shores developed the Therapeutic Relationship Model (TRM). This model enhances knowledge, skills and attitudes of a recovery approach to care in conjunction with the principles of managing therapeutic relationships while emphasizing the human contextual factors inherent in practice. This model is supported by Duxbury's (2002; Duxbury & Whittington, 2005) work on the internal, external and situational dimensions of managing violence and/or aggression and proactively preventing intrusive measures, as well as the work completed by Oades et al (2005) related to the components of the Collaborative Recovery Model.

The Therapeutic Relationship Model promotes patients' well-being and strengths while including the evidence that supports the value of the therapeutic alliance. It also supports a least restrictive and least intrusive approach with the ultimate goal to achieve positive patient outcomes. The model incorporates our recovery framework and promotes an understanding of the human contextual factors while utilizing the Six Core Strategies in Reducing Restraints and Seclusion as guiding principles.

The Model also promotes an awareness of the multiple factors that can influence staff's ability to effectively prevent and manage aggression. Duxbury and Whittington (2005) have narrowed these down to three conceptual frameworks: internal, external and situational.

The Internal Framework: Human Contextual Factors

The internal framework views the individual patient variables as the source of violence and aggression. Within the TRM, the internal framework has been defined as the *"human contextual factors"*. These factors are seen as the foundational building blocks of human beings. They are the characteristics that make up *"who we are"*. What creates the individuality amongst people is the extent to which each human contextual factor has been experienced and/or affected a person, resulting in variances in responses and behaviours towards similar situations.

Some examples of human contextual factors that are imperative for clinicians to consider within their assessment and evaluation of patients behaviours are:

- Trauma exposure
- Personal insight
- Knowledge
- Immediate stressors
- Communication
- Transference/counter-transference
- Mental and physical health
- Assumptions, values and judgment
- Interpersonal functioning
- Experiences
- Relational history

External Framework: Six Core Strategies

The second framework identified in literature is the external model which has been described as the environmental factors influencing patient aggression. Studies have examined space, location, unit regimens, and organizational routines as causative factor in patient aggression in mental health settings (Duxbury and Whittington, 2005). Historically studies have mainly explored psychosocial and physical aspects of unit-specific factors contributing to patient aggression. There are limited studies focusing on organizational strategies in managing patient aggression in mental health settings. The National Executive Training Institute (NETT) has developed the Six Core Strategies for the Reduction of Seclusion and Restraints based on extensive and ongoing literature reviews and dialogue with experts successful in reduction of seclusion and restraints and trauma-informed care (NASMHPD, 2003). The Six Core strategies focus on both the unit-specific and organizational perspectives which must be addressed from an external model standpoint related to management of patient aggression.

These strategies have been approved by the National Association of State Mental Health Program Directors (NASMHPD) and have been adopted within the Therapeutic Relationship Model to support the external model in the principles of managing therapeutic relationships within our mental health setting. The Six Core Strategies are evidenced-based and provide guidance for mental health settings to transition towards minimization of seclusion and restraints and promotion of trauma-informed care. The Six Core Strategies have been incorporated within the model to highlight the crucial role of the organization's support and commitment towards the management of relationships. The Six Core Strategies are: (1) Leadership towards Organizational Change; (2) Use of Prevention/Proactive Tools; (3) Workforce Development; (4) Debriefing Techniques; (5) Patient's Role in an Inpatient Setting; and (6) Use of Data to Inform Practice (NASMHPD, 2003).

These strategies stress the importance of the alignment of organizational values, mission and philosophy, policies and procedures, and action plans to support the reduction of seclusion and restraints and promotion of trauma-informed care. The strategies focus on gathering and continuous monitoring of data to inform decisions and implementation of interventions in restraint minimization and managing relationships. The workforce development strategy suggests *"the creation of a treatment environment whose policy, procedures, and practices that are based on the knowledge and principles of recovery and the characteristics of trauma informed systems of care"* (NASMHPD, 2003, p.2). The Six Core Strategies also support enhancing practice through staff development training and utilization of a variety of tools to support a proactive approach in managing relationships (NASMHOD, 2003). The highlighted key recommendations of the Six Core Strategies illustrate the value and influence the external model identified in literature has on managing relationships within a mental health setting.

Situational Framework: Collaborative Recovery Model

Duxbury (2002) reports on a number of studies, which support the value of a therapeutic nurse-client relationship, in particular when managing aggressive behaviours. These studies support the belief that a negative staff and client relationship can lead to patient aggression. The situational/interactional component is the third identified framework referring to the overall circumstance in which aggressive behaviours occur (Duxbury, 2002).

TRM incorporates the two guiding principles and four components of the Collaborative Recovery Model (Oades et al, 2005). The foundational principles of the Collaborative Recovery Model (CRM) support a preventative and therapeutic approach to mental health care, emphasizing recovery as a subjective and personal experience, which requires extensive collaboration between the client and mental health care provider (Oades et al., 2005). The CRM creates a recovery-oriented approach to mental health care with specific knowledge, skills and attitudes for practitioners.

The attitudes that are critical to the success of this paradigm shift are the possession of a growth mindset. Growth mindset is the hopefulness clinicians possess and able to demonstrate that patients have the ability to set, pursue and attain personally valued life goals. Other attitudes supported in this model are genuine collaboration, for clinicians to take partial responsibility in alliance ruptures (transference and counter-transference), the ability to use negotiation rather than coercion and staff understanding the value of between session activity (homework) (Oades et al., 2005).

Overall, it is essential to be aware and take into consideration the multiple dimensions, which affect therapeutic relationships to ultimately promote a therapeutic alliance and support quality of patient care and staff and patient safety. Increasing staff awareness and knowledge of the compounding dimensions in managing relationships will further support the proactive patient-centred recovery-oriented care in mental health.

Methodology

Ontario Shores' goals to reduce the use of restraints and increase the utilization of alternative interventions have steered the Organization towards a multifaceted methodology focusing on enhancing staff's knowledge, skills and attitude within the internal, external and situational dimensions of the Therapeutic Relationship Model. Key activities within this approach have included the following:

1. Development and training of new assessments and tools and the least restraint policy
2. Implementation of an organizational wide crisis intervention training, including mock Code Whites, to support staff in the shift towards a preventative/proactive approach
3. Reevaluating data collection and reporting of restraints

Development and Training on Preventative Tools and Practices

Ontario shores has developed and implemented a new policy for the emergency use of restraints to reflect best practices related to restraint minimization and trauma-informed care. Key practices essential to the policy are: greater frequency in physical and mental health assessments of patients expected from interprofessional teams and required external reviews for patients in restraints for an extended period. The least restraint philosophy embedded in the policy mandates all clinicians to adopt a proactive approach to care to prevent restraints and in the event of imminent risk, all least restrictive alternatives are exhausted prior to the implementation of restraints.

To support clinicians towards a proactive approach to care, specific standardized assessment tools have been implemented to aid in the early identification of changes to patient behavior and implementation of alternative strategies. Some examples of standardized assessment tools are: Mental Status Assessment, Risk Assessment to evaluate dynamic changes in behavior, and Behavioural Profile Tool. An Alternative to Restraints and Seclusion Guide has been developed as a resource for the interprofessional teams to utilize in collaboration with patients to mitigate the use of restraints and promote development of a therapeutic alliance.

Ontario Shores has also formalized the process for patient debriefing by clinicians caring for patients who have been placed in restraints or seclusion as its value has been validated in literature and is identified as one of the Six Core Strategies (Huckshorn, 2004). The intent of patient debriefing is to acknowledge the trauma or re-traumatization that may be caused as a result of a restraint event and help rebuild the therapeutic relationship between the health care team and patient, while maintaining the patient's dignity and well-being through respectful communication and collaboration. Clinicians are encouraged to explore and validate the patient's feelings and views about the incident, provide a clear explanation for the event, and collaboratively identify what both the patient and staff can do to prevent future restraint events.

Crisis Intervention Training

Ontario Shores' crisis intervention training is a mandatory program for all clinical staff, which lends focus to the early identification of risks and proactive approach to care related to predictable crisis situations and prepares staff to plan for the unpredictable crisis situations. The training program equips staff with skills and clinical knowledge to assist in the development of relationships through self-awareness, identifying unique verbal and non-verbal cues signifying early signs, symptoms and triggers of aggression, preventative planning, and an overall holistic approach to providing care in potential crisis situations.

Findings

Between 2008/09 to 2010/11, Ontario Shores has reduced the incidence of mechanical restraint by approximately 90%. The data from 2010/11 and 2011/12 demonstrates a further 36% decrease in incidence of chemical restraints but a minor increase in incidences of seclusion (approximately 3%). Ontario Shores continues to evaluate its data collection process, as the Organization has recently transitioned to a fully integrated electronic health record system which has provided far greater opportunities to enhance data collection and integrity and the ability to use the data to inform practice at the front lines.

Chart audits are completed on a quarterly basis to evaluate the documentation practices and review the utilization and adoption of the preventative/proactive tools. Most recent results indicate an increase in utilization of the assessment tools, further supporting the shift towards restraint minimization.

Discussion

Evidence in literature highlights reducing restraints and seclusion, changing attitudes of staff towards violence and aggression and prevention of aggressive/violent incidences cannot solely be accomplished through one distinct organizational strategy. A multifaceted approach of strategies influencing diverse staff in various aspects to support changing attitude, practice and culture has been adopted by Ontario Shores in its commitment towards restraint minimization.

Key successes have been leadership support from all levels, inclusion of all stakeholders throughout various initiatives, over communication and engagement of staff in various methods (i.e. classroom training, practice bulletins, real-time clinical situations).

Key challenges have been resources to implement and sustain the changes, internal stigma from clinicians, organizational culture, capturing accurate and meaningful data to evaluate practices and procedures, and defining standardized indicators that may be comparable to other like-organizations for benchmarking.

Next steps for Ontario Shores are to build on its sustainability strategies and further contribute to the mental health literature through conducting research to further inform clinical practice.

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Learning objectives

1. The importance of a multifaceted approach by a mental health organization to the prevention and reduction of restraint and seclusion.
2. How a large mental health facility planned, implemented, evaluate and sustain inter-professional models/ approaches that supports this practice.

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Characteristics of hospitalized patients with histories of multiple seclusion/restraint events and implementation of interventions

Paper

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Focus: Research
Keywords: seclusion, restraint, violence/aggression, multiple, prevention

Objectives

To identify the statistically significant characteristics of patients who are restrained or secluded (S/R) more than one during their hospitalization. With this data institute program changes and staff education to better care for our patients with the ultimate goal of reducing repetitive S/R episodes.

Introduction

This is a review of a study that examined all patients, over a three year period, who had more than one episode of seclusion or restraint (S/R) in an 88 bed acute adult inpatient psychiatric service at a large urban teaching hospital. The purpose was to understand the characteristics of these challenging patients and use this information to further reduce the use of S/R by improving nursing practice. The results, hypothesis generated and practice changes will be reviewed.

Seclusion and restraint use in the treatment of mentally ill patients is a dangerous practice. In 2005 our institution initiated a sweeping change in practice and culture through the use of a Crisis Prevention Management program that has resulted in a 90% reduction in the use of S/R. Despite this change, some patients continue to be restrained or secluded placing them and the staff at risk for injury or death. A large percentage of our S/R hours are generated by patients who are restrained or secluded more than once in a single hospital visit.

Purpose

To gain a better understanding of the characteristics of this more challenging patient population, to use this information to reduce S/R use through staff education and development of alternative interventions

Methods

Data, including but not limited to, discharge diagnoses (Axis I-V), history of prior aggression (pre hospitalization and during prior hospitalizations) and cognitive impairment is compared with the population of patients who were not secluded or restrained and those with only one episode of seclusion or restraint. Data was also collected examining the seclusion or restraint episode for duration, day, precipitants, medication use and presence of delirium.

Results

In our population patients with multiple events of seclusion or restraint were more likely to be male, have a history of prior aggression in and outside the hospital and a longer length of stay. Patients with any seclusion or restraint event were more likely to have cognitive impairments and be admitted involuntarily.

Interventions

Early assessment to identify risk factors and care needs is critical to reduce the risk of seclusion and restraint. Family members and caretakers of patients with cognitive impairments are crucial in this early assessment process. Staff have been educated and tools have been developed to gather patient specific care information, e.g. toileting schedule, favorite foods, calming activities. Effective communication was enhanced between team members with the use of simple tools.

Conclusion

Our results underscore the importance of primary and secondary prevention to identify patients at risk for behavioral disturbances and develop patient specific measures to support and prevent the occurrence of seclusion.

Acknowledgement

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Learning objectives

1. Identify all statistically significant characteristics of patients who are restrained or secluded more than once during a hospitalization.
2. State at least five patient or staff interventions utilized to decrease repetitive seclusion or restraint episodes based on the research findings.

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Witnessing: A tertiary prevention process to critically review each incident of seclusion or restraint

Paper

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Focus: Practice
Keywords: witnessing, tertiary prevention, seclusion/restraint, debriefing

Objectives

To elevate each incident of seclusion/restraint (S/R) to a critical level with a 360 evaluation, prevention of future incidents with a development of a patient specific plan and perpetuate the culture of crisis prevention management.

Introduction: Through the use of a Crisis Prevention Management program, an 88 bed acute adult inpatient psychiatric service at a large urban teaching hospital was able to reduce the use of seclusion and restraint by 90%. Witnessing, a tertiary prevention component of this program, provides a critical review after every episode of seclusion and restraint. This important process differs greatly from standard debriefing, and has been identified as an important means to maintain a culture of seclusion/ restraint reduction. Witnessing is used for factor analysis and examination of system issues, not to criticize staff decisions.

Method

The witnessing process is broken down into two separate steps with specific goals. The first part of this two part process involves the unit management team's review of the S/R event with those involved at the time of occurrence. This aspect is information gathering and identification of immediate staff needs. The second step involves a thorough review of the patient's history and course of hospitalization, an apology and dialogue with the patient allowing an opportunity for feedback, and a detailed review of the event with staff caring for the patient.

This forum allows an open discussion of what could have been done differently to have prevented the need for seclusion/ restraints, and what interventions need to be in place to prevent future episodes for this person. Inherent in the term witnessing is making public an important/nodal event. An experienced nurse from another unit participates by meeting with the patient and is used as a consultant during staff discussion.

Outcomes

Specific to the individual event we were able to accomplish the following:
- Immediate evaluation of each incident of S/R and elevation to a critical level,
- Explore disconnect between patient and staff perceptions of the event,
- Apologize to the patient and rebuild a therapeutic alliance,
- Engage staff in open discussion and problem solving,
- Expand the scope of review through the use of clinical experts outside of the unit,
- Identify staff concerns resulting in support, safety measures and system changes,
- Development of a patient specific plan with the goal of reducing future incidents.

Conclusion

We believe the development of a witnessing process has been integral to reducing our use of S/R. This aspect of the program is our best opportunity to evaluate present practice. It allows identification of educational needs, system changes, and provides immediate feedback on the car of individuals and groups of patients. It forces real time discussion and planning for getting patients out of S/R and attempts to repair the relationship so collaboration can be maintained. We learned many lessons along the way that led to process changes with how witnessing was practiced in addition we challenged our culture of care to provide better outcomes for our patients.

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Learning objectives

1. Participants will identify the key components and steps of the witnessing process.
2. Participants can state ways to develop a staff culture that accepts and acknowledges the value of witnessing.

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Chapter 15 - Engaging with service user in seeking solutions

Causes and management of patient aggression and violence in forensic settings: Staff and patient perspectives

Paper

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Focus: Research

Introduction

Aggression and violence against health care staff is a global problem (International Council of Nurses 2008). Nurses working in psychiatric facilities are one of the groups at greatest risk (Foster et al. 2007). It is therefore important to increase our understanding of the causes, prevention and management of aggression in psychiatric settings. A tool has previously been developed to investigate attitudes among staff and patients in general, acute mental health services (Duxbury 2003, Duxbury & Whittington 2005, Duxbury et al. 2008), but it is not known whether these results are generalisable to forensic/ secure settings. Forensic services hold a higher proportion of patients who have displayed violence (Bowers et al. 2011). Prevention and management of aggression and violence has been viewed by nurses working in secure and forensic settings as one of their key roles relative to their colleagues in general, acute mental health services (Mason 2008a, b). This study aimed to explore the attitudes about the management of violence and aggression among patients resident in a secure, forensic mental health service and among nursing staff employed in the same service.

Methods

Data collection was conducted in the low and medium secure wards of adult mental health care pathways of men's and women's services of St Andrew's Healthcare in May and June 2011. A prospective cross-sectional, comparative survey design was used. One of two researchers conducted a face-to-face interview with each patient participant. Demographic and clinical details of patient participants were collated from their medical records. A convenience sample of nursing staff was recruited by advertising on posters on wards and in emails. The 27-item MAVAS (Duxbury 2003) was used. Each item comprises a statement with which the respondent expresses their level of agreement or disagreement on a 100-mm Visual Analogue Scale. The minimum possible score on any item is therefore 1 ('strongly agree') and the maximum score is 100 ('strongly disagree'). MAVAS has been reported to have a valid four-factor structure (internal causes, external causes, situational/interactional causes and management issues) and to have good test-retest reliability (ibid).

Results

A total of 98 patient participants (see Table 1) and 72 staff (38 qualified nurses and 34 healthcare assistants; 33 males, 39 females) completed MAVAS questionnaires.

Internal causative items

Patients and staff both tended to agree with MAVAS statements about internal causes of violence and aggression. Patients were strongest in these beliefs to a statistically significant extent for three of five items. Patients agreed that a strategy of leaving aggressive patients alone will lead to them calming down whilst nursing staff disagreed with this statement.

External causative items

Patients were more likely than staff to agree that environmental issues were more likely to contribute to patient violence than did staff who responded more neutrally. However, both patients and staff agreed that a restrictive environment could lead to aggression.

Situational/ interactive items

Staff and patients tended to agree on the majority of these items. However, patients agreed with a statement that staff not listening was a contributing factor to aggression, while staff's views were more neutral.

Management items

Staff and patients tended to agree about items related to general management and the use of medication. Both agreed on the potential value of medication, and both tended to disagree that prescribed medication could lead to aggression. Both patients and staff appeared to believe that seclusion can be a helpful strategy, and neither group wished to see its use discontinued, although staff were far firmer in this belief than patients. Patients tended to believe that seclusion was overused in comparison to staff. Similarly, both staff and patients believed that restraint was sometimes necessary, but staff tended, at non-statistically significant levels, to disagree that it was overused relative to patients. Finally, both staff and patients were in agreement over a number of items related to the benefits of using non-physical or pharmacological interventions to prevent aggression and violence.

Discussion

We explored and compared the attitudes held by staff and patients in a forensic mental health service about aetiology and management of aggression and violence. Compared with previous studies conducted in acute mental health settings (Duxbury & Whittington 2005, Duxbury et al. 2008) forensic patients tended to agree more with staff about most MAVAS items related to the causes and management of aggression and violence. For instance, forensic inpatients agreed with staff about the use of de-escalation and other non-invasive techniques such as the need for improved communication or better one to one relationships. Neither did staff and patients disagree about the use of more coercive or active techniques such as the effectiveness of seclusion. Compared with a previous study (Duxbury & Whittington 2005) patients disagreed more with staff about the role of an improved physical environment; however this difference was the result less of agreement among staff as much as by more agreement among patients. The current study provides some evidence, therefore, that attitudes towards the causes and management of aggression and violence are different among forensic inpatients than among patients in acute settings and this may have consequences for their subsequent management. For example, our study suggests that forensic patients may be more realistic about, or possibly more resigned to, the proportionate need for coercive management techniques such as seclusion, restraint and emergency medication in response to violent and aggressive behaviour. Previous research supports our findings, for example that many similar patients felt that their most recent episode of seclusion or restraint was necessary though not, of course, desirable (Haw et al. 2011). However, this should not be taken to indicate that staff should simply apply active and coercive interventions in this setting; rather it indicates the need for improved therapeutic relationships and relational security because patients have longer lengths of stay and are more reliant on staff to meet their needs for acceptance, and to model appropriate behaviours that reduce aggression.

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Learning objectives

1. Staff and patients in forensic mental health settings do not radically differ in their views on the causes and management of aggression and violence.
2. Previous reports of tools to measure attitudes were not validated in a forensic setting suggesting a need for development of new measures.

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Issues in supporting victims of domestic violence in rural cities in F Prefecture, Japan

Poster

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Focus: Organisational

Abstract

Purpose

This study was conducted to examine issues in supporting victims of domestic violence (DV) in rural cities in Japan and to obtain information useful to building support systems for DV victims.

Methods

An anonymous self-report questionnaire was mailed to all 39 facilities that offer support to DV victims in F Prefecture. The survey asked respondents to write freely about issues in collaborative efforts and consultation during the provision of support for DV victims. Words and phrases that were deemed indicators of such issues in each context were extracted and codified, and their meanings were examined. Similarities and differences in codes were extracted and grouped as categories by meaning.

Results

Responses were collected from 34 (87.2%) facilities, including 9 prefectural spousal violence counseling and support centers, 16 municipal spousal violence countermeasure divisions, 5 facilities participating in liaison conference for countermeasures of spousal violence, and 4 private support organizations.

Issues related to collaborative efforts consisted of three categories: difficulties in collaboration, adequate network in community support, and collaboration with local residents. In difficulties in collaboration, three subcategories were identified: few opportunities for collaboration, difficulties identifying the occurrence of DV, and different perspectives among facilities for victim support. The adequate network in community support category had three subcategories, namely vitalization of DV liaison conferences, provision of information about each facility's DV victims, supports, and division of roles for each facility. For collaboration with local residents, one subcategory was extracted, namely local residents as a collaboration partner.

Issues related to consultation consisted of two categories: the presence of supervisors and backup systems during consultation staff absences. In the presence of supervisors category, three subcategories were found: concerns held by consultation staff, significant physical and psychological burden, and the need for supervisors. Backup systems during consultation staff absences had two subcategories: difficulties in responding properly during staff absences and 24-hour systems for face-to-face and telephone consultation.

Discussion

The issue of adequate network in community support linking various facilities, we identified a category labelled collaboration with local residents, which suggests the need to establish networks with local residents who can act as collaboration partners. In difficulties in collaboration, we identified there are difficulties identifying the occurrence of DV, few opportunities to collaborate, difficulties sharing information, and little clarity in the division of roles among the relevant organizations including responses during staff absences. This suggests frustration among facility staff whose wishes to enhance collaboration with various other facilities remain unrealized.

A category that emerged from the analysis revealed the need for a supervisor. Consultation staff reported feeling unsure whether their support was appropriate and working while feeling distressed due to listening to the victims, experiences. In addition, the respondents identified backup systems during consultation staff absences, such as when having to respond in a system where there is only one consulting staff member employed. Also, to support the consulting staff, it is essential to create systems that provide opportunities for them to discuss the direction of support with other staff and to assign supervisors.

Learning objectives

1. To be able to explain issues related to collaboration with multiple organizations when supporting DV victims.
2. To be able to explain issues when providing consultations to DV victims.
3. To be able to explain the support systems necessary for DV victim support.

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Understanding and responding to relational aggression between staff nurses and student nurses

Paper

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Focus: Research

Abstract

Nursing is known as a caring profession and nurses are often seen as heroic figures who assist patients through their darkest hours. Indeed, nurses work long and difficult hours to assist patients to feel better or come to a peaceful death. Unfortunately, for all of their positive characteristics, nurses (like all human beings) have a dark side to their nature. The expression that nurses eat their young is well known to nursing professionals. This incivility towards one another is known as relational aggression and is perceived within the profession as an issue affecting nurses well-being, recruitment, and retention. Relational aggression is practiced against nursing students seeking entre to the profession as well. From a leadership perspective, the researcher seeks to understand and formulate a response based upon the lived experiences of nursing students and interview responses of the staff nurses charged with educating students during clinical rotations.

The primary methodology used in this research is phenomenology in an attempt to gain deep insight into the student nurse experience of relational aggression. In addition, staff nurses will be interviewed to gain perspective on gateways and barriers to working with students during clinical rotations. Finally, senior nursing leaders in hospital and nursing schools will be engaged in dialogue to seek solutions based on the research findings.

This research is in progress. The researcher seeks to share findings and engage other conference attendees.

Learning objectives

1. Attendees will gain insight into the nature of relational aggression as it affects student nurses.
2. Attendees will be able to formulate effective solutions that will enhance the development of a productive learning environment for student nurses in clinical rotations.

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Doing time and intimate partner violence: Trajectories among women leaving prison

Poster

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Focus: Research

Abstract

Background and context

At present the annual recidivism rate among 7000 admissions to female correctional centres in Canada is 40% within one year and 75% within two years. Few researchers have conceptualized imprisonment as an outcome of a disordered health and social environment. The overwhelming majority of women in prison have been subjected to poverty, child abuse, and role modeling of criminal behavior by parents and, as adults, domestic violence

Study aim

Our aim is to work with incarcerated women to improve our understanding of factors that prevent or facilitate their re-integration into society.

Methodology

In a cohort analysis, we followed 407 women following release from provincial prison in British Columbia, Canada, to evaluate the impact of exposure to intimate partner violence (IPV) on their post-incarceration trajectory. Interviews were conducted at release and three months later by phone or in person with community-based peer researchers who themselves had been previously incarcerated. The Abuse Assessment Scale was utilized to assess exposure to violence.

Findings

Twenty three percent of women had experienced physical violence from their intimate partner since release. Compared to women not exposed to IPV, these women were more likely to have low self esteem, 27.3 vs. 15.3% as measured by the Rosenberg self-esteem scale, report their quality of life as poor (78.2 vs. 41.7%), and require medical care (60 vs. 39.7%) in the first three months after leaving prison. They were more likely to be injecting drugs (28.8 vs. 10.8%), and obsessing about using drugs (98.2 vs.76.6%). They were less likely to be homeless (13.6 vs.21.7%).

Implications

Women leaving prison have a higher prevalence of intimate partner exposure in the first three months, and this is associated with poor self esteem, poor health, and injection drug use. Women may be choosing to live with violent partners as an alternative to homelessness. Women leaving prison need assistance to access safe housing as part of discharge planning and violence prevention.

Learning objectives

1. To understand vulnerabilities of women leaving prison.
2. To understand outcomes of violent experiences among women prison-leavers.
3. To understand relationship of violence and homelessness.

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Check yourself before you wreck yourself: Self-care in high stress workplaces

Poster

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Focus: Practice

Abstract

Background and context

We all work in stressful environments and our emotions affect us, our colleagues, our clients, and our workplace overall. Identifying and dealing with our own emotions, pain, and stress can help us to be better leaders within our organizations. Checking yourself is a first step in caring for yourself - ensuring you do not burn out - so you can do your job better in the tough arena of patient care. We all need to take the time to assess our physical, mental, emotional, and spiritual well-being.

Methodology

The subjects of this work were registered nurses, social workers, and mental health professionals. A qualitative survey was developed through data collected during a literature review process focused on self-care, lateral violence, and horizontal hostility. Snowball sampling or respondents aided in the dissemination of the questionnaire. Electronic communication and feedback focused on developing self-care and self-assessment tools. Subsequent questions looking at the impact of culture on self-care and burnout developed. Themes emerged on client versus provider first models, balance between *"givers"* and *"takers"*, and a sample questionnaire was developed to assess personal and team well-being.

Findings

From this study it was learned that health systems need healthy providers before we can put patients first. Knowing what your philosophy is can help support your practice and preserve you.
Knowing who you can turn to for feedback was important. Strategies emerged relating to seeing a doctor, nurse, or someone you trust for a check-in and a check-up; having some relief from care-giving, accessing a social worker; and starting or joining a support group for care-givers. Addressing violence and wellness was supported by developing positions statements for yourself or your team focusing on a commitment to co-workers.

Implications

This qualitative work looks at strategies to support the individual in the health system. We do not work in isolation, and we need to be healthy in order to engage clients. Health care workers need to look after ourselves and our teams. Finding balance and managing energy are ultimate goals. Focusing on self-care is more important than always have to fix things. Self-Care is ultimately up to you and your team. As health care professionals, we provide support, education and care that impacts patients and their families to attain optimal health outcomes. It is important for us to remember that we are not helpful to others if we have not taken care of ourselves first. Compassion fatigue is something that prevents us from delivering high-quality, patient centered care, and it is important to function at the highest level within a healthy team. Organizational change starts with individuals where transformation is supported through a strong, inter-professional workforce. Ultimately, when we look after ourselves, we have more opportunities to create innovation and to deliver optimal care to patients. Health care workers need to stop focusing on solving problems, and we need to look after ourselves first before we can move forward. Knowing what your self-care philosophy is can help support your practice and preserve you.

Learning Objectives

1. To review strategies and tools to develop a commitment to safe working environment in health care settings that supports the individual and team members.
2. To identify the importance of self-care needs and describe actions to maintain and implement self-care approaches for balance in work-life relationships.

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Trade Union campaign and posters 'Dont hurt your Carer!' in 2011, and campaign results

Poster

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Focus: Practice

Abstract

Background

Violent behaviour by third parties threatens the safety and health of carers. Finland has also reported an increase in violent incidents occurring in the workplace for the health care sector during the last few decades. Statistics of injuries occurring in the workplace, and surveys conducted amongst care professionals, provide ample evidence for this. In the spring of 2007, the State Auditors submitted a memorandum to the Parliamentary Speakers Council regarding the provision of legal safeguards for health and social care professionals facing potentially violent situations. According to the Federation of Accident Insurance Institutions (TVL) of the reported workplace injuries (total 96,368), which were compensated by insurance companies, approximately 1.5 % involved violent incidents occurring in the workplace (total 1,464). Of these reported cases 58 % (total 850) involved violence to women. In Finland the law on health and safety at work stipulates that an employer must formulate an action plan for any situation where violence is likely to occur.

Purpose

On the basis of statistics and survey results (from 1st March 2011 to 31st December 2012), Tehy, the Union of Health and Social Care Professionals (membership of 153,000), decided to launch a poster campaign with the slogan Dont hurt your Carer!. This was intended to open a debate on violence in the workplace of health and social care personnel.

Methodology

Two different versions of the campaign poster Dont hurt your Carer! were printed (10,000 copies of each). One was intended for display at public places and the other one (included 7 clauses) was for the use of health and social care personnel. At the same time a series of slides depicting violence in the workplace was devised for the use of members of union branches and health and safety representatives. Early in 2012 Tehy conducted a survey on the effectiveness of the poster campaign. The survey covered 282 branches and 76 health and safety representatives. Facebook pages which were committed to this campaign were devised in May 2011 and by the 10th of September 2011 the pages had received 36,000 hits.

Findings

The poster campaign was regarded effective and giving a clear message. According to feedback from union branches this campaign had raised awareness of violence in the workplace, including the threat of violence (45 % agreed). Incidents of violence were now more frequently recorded and reported (31 % agreed). Health and safety representatives reported that as a result of this campaign changes and improvements were made to the working practices (11 %), to information and to warning procedures (14 %), to follow up actions after a violent incident (10 %) and to safety equipment (7 %). Reporting of dangerous and threatening incidents increased during the campaign (24 % agreed). It was thought that this campaign had generated open debate amongst the participants, whereas previously those issues were sidestepped. The supporting series of slides were not much in demand. This campaign received national publicity both on television and in the press.

Conclusion

Violent incidents and the threat of violence in the workplace cause considerable stress to health and social care personnel. The trade union, as one of the social partners, has the responsibility to raise these issues for debate at both national and workplace level. This can help to identify potentially violent situations by improving the environment, procedures and skills in the workplace. The message from the Health Care Centre was: The patients discussed these posters at the Health Care Centre ward with the nurses. The posters also made the relatives of the patients to consider issues from the perspective of the nurses.

Learning objectives

1. To demonstrate the effectiveness of campaigns.
2. To demonstrate the usage of social media.

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Domestic violence against women: incidence and prevalence in an emergency department population

Paper

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Focus: Research

Abstract

Objectives

A majority of women entering the hospital emergency departments and walk-in clinics in Sydney are likely to have a history of domestic violence. Domestic violence involves a physical injury, emotional and/or psychological threat by a male partner. The aim is to identify this group of women and to intervene early by referring them to counseling and other services.

Method

A prospective study was conducted to screen women of domestic violence who agreed to participate and who were accessing the Emergency Department during three months of the study period in May to July 2011. The validated Hurt Insult Threatening Screening tool (HITS) consisting of 4 questions was used. Data was analysed using descriptive statistics and two-group comparisons. The incidence and one month cumulative prevalence rates of DV were calculated with 95% confidence interval and correlates of DV were examined.

Results

Of 239 women in Sydney, who previously sought emergency care and completed the questionnaires, 102 (47%) had experienced threats or injuries from a current male partner in their lives. Physicians and nurses in emergency department failed to detect the history of domestic violence in women seeking treatment. Of the 239 women in the study with a male partner, 11.7% accessed the emergency room for acute domestic violence, but only 13% of these said they either told or were asked about domestic violence by the health practitioner.

Conclusion

The incidence of acute domestic violence is not as common among the women visiting the emergency department as previously reported. Although the cumulative prevalence of domestic violence is strikingly high, women who have experienced domestic violence are seldom identified by the emergency department professionals.
Keywords: Women, Domestic violence, Prevalence, Emergency department

Introduction

One in three Australian women have experienced physical violence since the age of 15 years [1], and almost one in five have experienced sexual violence [2]. In 2005, over 350,000 women experienced physical violence and over 125,000 women experienced sexual violence [3].
Domestic violence (DV) is a term that refers to a wide range of physical, sexual, emotional and financial abuse of people who have intimate partners – whether or not they are married or cohabiting [4]. Intimate Partner Violence (IPV), otherwise known as Domestic Violence, is a pattern of physical, sexual, and psychological attacks that adults use to control their intimate relationships [5]. Domestic violence is considered to be a behaviour that results in physical, social and/or psychological damage, forced social isolation, or economic deprivation which causes the victim to live in fear [6]. These behaviours are perpetrated by someone who is known to the victim [7].

Background of the study

International awareness of domestic and family violence as an issue of significant social concern has increased over the past three decades. This violence knows no geographical, socioeconomic, age, ability, cultural, or religious boundaries. There is no universal national or international accepted definition of violence against women [8].

The issue of violence and mental illness is complex and intertwined. While it is well known that exposure to violence impacts on physical health, the effects on one's mental health areless visible. Domestic violence is linked to a wide range of mental health problems including post-traumatic stress disorder (PTSD) and complex trauma, anxiety, depression and problems with alcohol and other drug use [9]. Recent research shows that the experience of having lived with a violent partner is linked to having a diagnosed psychological disorder, recent

experiences of depression and anxiety and overall decreased psychological wellbeing [9]. An Australian study found that experiencing gender-based violence was significantly associated with mental health disorder, dysfunction and disability [10]. Furthermore, a high percentage of individuals using the mental health system have experienced multiple traumas [11].

Laing [12] has highlighted several issues for women with mental illness who are experiencing domestic violence including: their claims of abuse that are often seen as less credible and not taken seriously by health professionals due to time constraints and are quick to prescribe medication for symptoms of violence and abuse (depression and anxiety) which means that women may not have access to information and supports. However, most women who are being abused by their partner rarely disclose this problem especially whereby accessing the health care settings [12]. Barriers to disclosing abuse are both internal, such as lack of hope for change, embarrassment, fear of reprisals or disbelief, or they may be external, such as social isolation, inappropriate services, or perceptions that health professionals are unable to help or are only there for physical problems [4, 12]. Confidentiality is also a concern, particularly the potential for involvement of child protection services, which may result in the woman losing custody of her children [4].
The South Australia's study [13] confirms that the use of EDs is estimated to be three times higher for women experiencing intimate partner violence than non-abused women. Therefore, early identification and intervention by the health proferssional has the potential to reduce the number of health problems associated with domestic and family violence, and lead to considerable health benefit to patients and society.

In the Australian literature, there is little emphasis on ED nursing services and their role in providing services for women with domestic and family violence issues [12].

Purpose of the study

We conducted this prospective study to answer the following questions about violence against women by male partners:
(1) What is the incidence of acute DV in an Emergency Department population?
(2) What is the cumulative prevalence of exposure to DV, either recent or remote, in women seeking care in an ED?
(3) Can clinical or demographic attributes identify women most likely to have experienced DV?
(4) What proportion of women subjected to acute DV who seek care in an ED are detected by ED staff?

Subjects and method

Study design and setting

A convenience sample of all female patients visiting a busy, Emergency Department (ED) of an inner-city hospital in Sydney with 45,000 visits per year were surveyed between May to July 2011. Patients were eligible if they were at least 18 years old, fluent in English, and able to give informed consent. All clinician on-site were provided with A Handbook Dealing with Woman Abuse and the law [14] before the study. The study was approved by the Area Health Ethnic Committee.

Data collection procedures

Research assistants (RAs) were trained to ensure a consistent verbal script for recruiting eligible participants. A brief invitation letter was placed in the medical charts of all adult female patients with booked appointments for follow-up and walk-in to the ED. The receptionists gave the invitations to patients when they checked in. Patients were then approached in the waiting area by the RAs. After confirming eligibility, patients were informed about the purpose and nature of the study in a separate room where they would be unaccompanied by family members or friends. Willing participants provided written consent and completed the 7-10 minute written questionnaire before seeing their clinicians. Women were assured that the completed questionnaire will remain confidential; information will not be made available to ED staff. However, after the questionnaire was completed, they were encouraged to share any concerns about personal injury or violence with the physician. In addition, the RAs offered written pamphlets concerning DV, including local resources, a health information with telephone numbers of counselors and a help line for assaulted women.

Questionnaires

The Hurt Insult Threaten Screening Tool (HITS) was used to screened patients for domestic violence [15]. HITS is one of the shortest validated screening tool that has been tested with diverse populations and used in family medicine practices. HITS is comprised of the following four items: (1) *"How often does your partner physically hurt you?"* (2) *"How often does your partner insult you or talk down to you?"* (3) *"How often does your partner threaten you with harm?"* and (4) *"How often does your partner scream or curse at you?"*

Patients were asked to rate their responses from 1 to 5. Responses were summed to form an interval scale of the total HITS score, which could range from 4 to 20. Using a cutoff score of 10.5, Chen et al [16] found that HITS accurately classified 91% of non-victims and 96% of victims. HITS has a Cronbach's α of 0.80 and is highly correlated with the Conflict Tactics Scales ($r = 0.85$) [16, 17]. In our study the Cronbach's α of 0.76.

The survey consisted of three sections: sociodemographic, health-related variables, and patients' experiences of IPV. While the first and second sections applied to all participants, the IPV section applied only to those in current or recent intimate relationships. The term *"intimate partner"* referred to a spouse, common-law partner,

or boyfriend. A recent relationship was defined as an intimate relationship of at least one month' duration during the last year.

Incidence and prevalence of DV and IPV

The incidence of DV was determined to an answer of yes or unsure to one or both of the following questions: 'Are you here today for injuries from your male partner?' or 'Are you here today because of illness or stress related to threats, violent behaviour, or fear from your male partner?' To avoid under estimating the incidence of acute DV, we included 'unsure' as a positive response to the item. Only women with current male partners were asked these two questions.

To determine the cumulative prevalence of DV, questions were asked about any DV episodes with current or past male partners. The cumulative prevalence of DV was determined as a positive or unsure answers to either of the questions (above) pertaining to acute DV or a positive answer to one or more of the following questions about current male partners: If this had happened within one month, women were considered to be positive for one month prevalence.

Experiences of IPV

Experiences of IPV were assessed using HITS scales, along with questions recommended in Ramsay et al's study [18] about health care professionals screening of domestic violence. The study also examines emotional and physical violence and threat of violence. Emotional IPV was the response to: (1) partner's jealousy; (2) controlling; (3) isolation from family or friends; and (4) insults. Threat of IPV was assessed by responses to: (1) fear of disagreeing with partner; and (2) feeling physically threatened by partner or otherwise physically hurt; and being forced to have unwanted sex. Patients were asked to respond either *"yes"* or *"no"* to each question. We determined participants as IPV victims if they responded *"yes"* to at least two items on emotional violence or one item on threat of violence or physical violence.

Attitudes toward screening for DV

Attitudes toward the screening were assessed using the four attitude domains: (1) patient-perceived benefits for quality of medical consultation; (2) means of achieving them, (3) privacy-barriers, which covered patients' concerns about information privacy; and (4) interaction-barriers, which meant concerns about interference during interactions with physicians.

Data analyses

Data was analysed using descriptive statistics and two-group comparisons. The incidence and one month cumulative prevalence rates of DV were calculated with 95% confidence interval (CIs) and correlates of DV were examined. Associations between demographic variables and incidence and cumulative prevalence rates of DV were tested using Student's t test for continuous variables and x2 for categorical variables. Data were analyzed using the Statistical Package for the Social Sciences, version 20 [19].

Results

Sociodemographic characteristics

Participants had a mean age of 33.3 years (range, 19 to 66); 75% of them were in current or recent relationships (see Table 1). About 36% were immigrants, and 59% of these had lived in Australia for more than 20 years. Most participants had at least some university education and were currently employed. They rated their health as *"good"* with a mean score of 3.2 (SD ±1) on a scale of 1 to 5. They had visited family physicians during the past year a mean of 4.6 times (range 0 to 30).

Prevalence of DV

The total of 265 women who presented at the ED for care during this period, of these women, 239 completed the questionnaire (90%), 113 women who completed the questionnaire declined participation with further questioning. This group was older than 102 participants group, with median age of 38 years [range, 19-75]. One hundred two (47%) women reported having been threatened or physically injured by a husband or boyfriend at some time in the last year (cumulative prevalence, 52.2%; CI - 52.2%) (see Table 3). Women who were with a current male partner were 24 (11.7%) (95% CI - 8.7% to 15.2%). Only 11 (23%) of these women screened with acute DV presented for care because of trauma, 6 (13%) either told staff about DV or were asked about DV by ED professionals. Among 102 women without current male partners, 13 (5.6%) reported an episode of DV within the previous one month and 28 (28.5%) reported within previous one year. For the entire sample, the cumulative lifetime prevalence of DV exposure was 54.2% (95% CI - 50.2%).

Table 3. Domestic Violence Incidence among women with a male partner (N=239)

Questions	Yes	Unsure	No
*Are you here today because of illness or stress related to threats, violent behaviour, or fear from your husband, partner or boyfriend?	196	21	
*Are you here today for injuries from your husband or boy friend	9	13	
Total			239

*number indicate number of women who responded to the questions. Numbers are mutually exclusive. 'unsure' responses include only those women who answered 'unsure' to both of the preceding questions

Experiences of IPV

Of 102 respondents to the IPV section, 29 women reported at least one experience of violence, 18 of those perpetrated by current partners; 10 by recent partners; and one by current and recent partner. Using our IPV case definition, the prevalence of emotional IPV was 10.4% (95% CI - 5.4 to 15.4), threat of IPV was 8.3% (95% CI - 3.8 to 12.8), and physical or sexual IPV was 7.6% (95% CI - 3.3 to 11.9) (see Table 2). Many patients who reported emotional IPV also reported threat of IPV (60%, Fisher's exact test: $P \leq .001$) or physical IPV (53%, Fisher's exact test: $P \leq .001$). Counting IPV victims only once across three types of IPV the overall prevalence was 14.6% (95% CI - 8.8 to 20.3). Comparison of victims and non-victims of IPV showed that victims had lower household incomes ($t=2.1$, $df=131$, $P < .01$), but were similar in other sociodemographic and health-related variables, including comfort level with completing the survey and Australian-born versus immigrant status.

Table 1. Socio-demographic characteristics (n=239)

Variable	N	%
Marital status	239	
• Married		54.6
• Separated, divorced, or widowed		13.9
• Single, in current relationship		20.3
• Single, not in relationship		11.4
Had children	113	56.2
Country of birth		
• Australia		63.9
• Outside Australia		36.1
If an immigrant, years lived in Australia	170	
• <10		23.9
• 10-20		16.9
• >20		59.2
If an immigrant, country of birth	170	
• Europe		36.8
• East, Southeast		39.1
• South East Asia		9.2
• Arabia, West Asia		6.6
• Africa		4.1
Education	239	
• Less than high school		3
• High school		19.9
• University		55.7
• postgraduate		21.4
Employment Status	239	
• Full-time		49.8
• Part-time		14.4
• Unemployed		13.9
• Retired or disability		21.9
Household income ($)	181	
• <30000		15.5
• 30000-50000		19.9
• 50000-70000		20.5
• >70000		44.2

Table 2. Responses to questions on intimate-partner violence (IPV) in current or recent relationships (N= 102): Overall, 21 respondents (prevalence was 14.6%) reported being victims of violence (victims were counted once across the 3 types of violence).

Questions	N=102	% of respondents Saying 'Yes' (9.5% CI)
Emotional Violence*		
• Is your partner very jealous?	14	7.6 (3.3-11.9)
• Does your partner try to control your life?	16	10.4 (5.4-15.4
• Does your partner try to keep you away from family and friends?	12	6.3 (2.3-10.3)
• Does your partner insult you or put you down?	22	12.5 (7.1-18.0)
• Pooled responses of those saying 'yes' to 2 or more items in the emotional domain	10	10.4 (5.4-15.4)
Threats		
• Are you afraid to disagree with your partner?	12	6.3 (2.3-10.3)
• Do you feel physically threatened by your partner?	8	4.9 (1.4-8.4)
• Pooled responses of those saying "yes" to feeling of threat	6	8.3 (3.8-12.8)
Physical or sexual violence		
• Has your partner ever pushed, hit kicked, or otherwise physically hurt you?	9	5.6 (1.8-9.4)
• Has your partner ever forced you to have sex when you did not want to?	9	5.6 (1.8-9.4)
• Pooled responses of those saying 'yes' to any aspect of physical or sexual violence	5	7.6 (3.3-11.9)

*Note: Each item is scored from 1 to 5. Scores for this study ranged from 4 to 20. A score greater than10 is considered positive. * 17.4% of respondents reported at least 1 experience of emotional violence (95% CI 11.2-23.6)*

Correlates of DV

Table 4. Rates of Domestic Violence among women in Emergency Department

Type of Violence	No (%)	95% Confidence Interval
Acute DV incidence	29(11.7)	8.7-15.3
DV of current partner	32(32.6)	23.4-32.3
1-mo prevalence (102)	13(11.9)	9.5-14.6
1-y prevalence (239)	28(15.3)	12.6-18.3
Cumulative prevalence (239)	129(54.2)	50.2(58.1)

**Numbers in brackets indicate number of respondents*

Of the 239 women who had been threatened or physically injured by a partner at some time in their lives, the cumulative prevalence was 54.2%; 95% CI, - 50.2% to 58.1%) (see Table 4). There was no significant association between a history of DV and ethnicity. Several correlates of DV exposure (cumulative prevalence) were identified. Eighty one percent (81%) of women with a history of suicide attempts had experienced DV at some time in their lives, compared with 19% of those with no history of suicide attempts ($P < .001$). This concurred with prior study that women exposed to acute or prior DV were more likely than unexposed women to have made suicide attempts and to report excessive ethanol use [5, 8, 9].

Discussion

Domestic violence takes many forms ranging from homicide, rape, and battering to threats of violence, verbal assaults and other forms of intimidation. It is an incontrovertible fact that DV represents an important health threat to women. This is the first study in our hospital reporting on the prevalence of IPV among female patients visiting the ED. The results highlighted that if a clinician sees 150 patients a week, half of whom are women in relationships; our prevalence rate of 14.6% implies that a physician is likely to see 11 victims of IPV every week. Given this high prevalence and women's reluctance to disclose, clinicians need to be highly vigilant to screen cases of IPV.

Clinicians in hospital could be pivotal in detecting IPV and offering empathy, support, and referral to helping agencies [20, 21]. Studies report that the risk of anxiety, depression, suicide attempts, and symptoms of posttraumatic stress disorder is much lower among women suffering from IPV if they have strong social support [4]. Forty five women who contacted advocacy services report that concerned nurses and physicians motivated them to seek help [11]. Longitudinal research indicates that referral to specifically tailored counseling services benefits victims of abuse by helping them learn to reduce emotional or physical abuse and improving their quality of life. Clinicians could empower abused women by promoting social support, self-worth, and internal locus of control, decision making, and use of counseling services.

This study is especially important for abused women as specific inquiries by health care providers give them permission to disclose when completing surveys, and patients are likely to learn more about, and reflect on their

risk before they see their physicians. Future research should examine the actual use of screening by patients and providers and assess its effectiveness in primary practice.

Inquiring about emotional IPV is important. We found strong correlations between emotional and physical IPV. Traditionally, researchers and clinicians have focused on screening for physical violence, but emotional abuse is part of a larger pattern of domination and control. Emotional abuse precedes physical abuse or has consequences as damaging as physical abuse asking about emotional IPV would help in early detection and timely management of risk, so clinicians and health educators need to broaden their current definition of IPV. Screening can provide a form of primary prevention within the community [12], as well as secondary prevention if adequate support services are in place.

Limitations

We acknowledge that our sample is small and results might have limited generalisability because the study was conducted in only one hospital. This hospital, however, had several clinicians on staff and served a large number of diverse patients' groups. However, we recruited patients with a variety of reasons for the ED visits including all three shifts to increase generalisability. The study had a high response rate, and reassuringly, participants were similar to women residing in Sydney in terms of immigration and marital status. The results, therefore, can likely be generalised to similar practice. Our rates of IPV, however, might underestimate the real magnitude due to under-reporting.

Implications for practice

The results of the study demonstrated that DV is a common presenting complaint among women visiting EDs and clinicians do not detect most women at risk. The data presented here supported the recommendations of the Consumer Advisory Group for Mental Health to improve methods of detection, counseling and referral for DV in emergency settings. Provider reluctance to ask about abuse is a significant barrier to patient disclosure of domestic violence [16], although other factors may also interfere with this process [10]. Early identification and intervention by the health system may reduce health problems associated with domestic and family violence and lead to savings for the health sector.

Conclusion

This study shows significant rate of IPV among women and the need for all clinicians to be vigilant. This implies both complex and serious issues relating to domestic and family violence, which, without the screening program, may have never been addressed by the ED nurses. Thus, at the micro level, this implies an improved service for women. Future research should examine ways to help ED nurses and physicians inquire into IPV and conflict in relationships.

Acknowledgement

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Learning objectives

1. Inquiring about emotional IPV is important. We found strong correlations between emotional and physical IPV. Traditionally, researchers and clinicians have focused on screening for physical violence, but emotional abuse is part of a larger pattern of domination and control. Emotional abuse precedes physical abuse or has consequences as damaging as physical abuse asking about emotional IPV would help in early detection and timely management of risk, so clinicians and health educators need to broaden their current definition of IPV.
2. It is especially important for abused women, as specific inquiries by health care providers give them permission to disclose when completing surveys, patients are likely to learn more about and reflect on their risk before they see their physicians. Future research should examine the actual use of screening by patients and providers, and assess its effectiveness in primary practice.

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Chapter 16 - Education and training

Nurses supporting nurses: Hear the nurses' voices as they engaged in courageous conversations together

Paper

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Focus: Education and Training
Keywords: Conflict; courageous; open-dialogue; appreciative inquiry; art of possibility; work environment

Introduction

The Courageous Conversation project is an innovative engagement workshop created and implemented by a frontline staff nurse. The workshop is designed so that nurses can participate and engage in an open dialogue regarding the issues that commonly results in conflict and together find resolutions on how to resolve them.

Conflict is a common experience among nurses. When nurses are not happy at work because of unresolved conflicts, many problems arise. An atmosphere of mistrust and disrespect creates downward spiral conversations and open hostilities. At a time when enormous workload, limited staff resources and a fast paced environment predominates the work landscape, conflict would be disastrous to everyone, especially to patients and families who rely heavily on the expertise of their health care providers.

Nursing is a profession rooted in human-to-human relationships. Being able to talk to colleagues and team members with respect, dignity and mutual desire to seek understanding as well as resolve conflict is as important as the way in which nurses engage with patients and families. Programs that can help staff to cope and resolve conflict effectively need to be in place.

Conflict is defined as *"clashing of two opposing interest"* (Stuart & Sundeen, 1995). Conflict occurs on four levels: (1) intrapersonal conflict occurs within an individual to clarify contradictory values; (2) interpersonal conflict occurs when two or more individuals have contrasting values, opinions and beliefs; (3) intragroup conflict occurs within a group; and (4) intragroup conflict are those that arise between two or more groups of people, departments or organization (Dove, 1998). In 2005, Statistic Canada indicated that both female (44%) and male (50%) nurses reported exposure to hostility or conflict from coworkers, proportionately higher than the general population (<30%) (Statistic Canada, 2005). Cox (2001) reported that interpersonal relations and unit morale directly affected conflict resolution within the group (p. 23). A later study by Cox in 2003, on the effects of intrapersonal conflict on the effectiveness of team performance and work satisfaction, indicated that intrapersonal conflict had direct negative impact on work satisfaction and team performance. Furthermore, she noted that conflict within the individual would carry over into conflict within the group (p. 8).

Conflict is not always a bad thing. According to Smith, Strickler & Tutor *"constructive conflict with positive resolutions may enhance relationships, provide freedom for decision making, empower others to use creative solutions for problem solving"* (2001, p.37). Brant, Holt & Sullivan (2001), discussed the culture of sharing and fostering an environment where staff nurses are allowed to solve conflict among them. For this to work, nurses need to know how to collaborate, understand and appreciate the different value system and shared decision-making (p. 32-33). Conflict creates an atmosphere of mistrust and disrespectful behaviors. Sometimes it can be unbearable and nurses will call in sick just to avoid being subjected to this environment. Occasionally, small discussions escalate to disagreement and feelings are hurt (Northam, 2009). There are many challenging personalities in the workplace and the resulting negativism undermines the positive and caring nursing environment. Overbearing personalities and behavior challenge the authority of leadership and contribute to unhappiness and staff dissatisfaction (Padrutt 2010).

Managing conflict effectively, respectfully and positively will promote good working relationships among nurses. Nursing Leadership must support and enable the implementation of conflict resolution programs and strategies so that nurses will feel valued and respected. These programs should be made accessible to nurses. Both Cox (2003) and Dove (1998) agreed that managing conflict effectively leads to staff satisfaction and a respectful work environment.

The advantages of resolving conflict in the workplace have been well documented by Northam, (2009) and Baker (1995). They both agreed that nurses should possess effective conflict resolution skills in order to be successful in a team environment and become empowered so they stay in the nursing profession. A study by Siu, Laschinger and Finegan (2008), reported that effective conflict resolution skills with positive outcomes is limited. Furthermore, they concluded that increasing reports of hostility and unresolved conflict among Canadian nurses is a great concern. In addition, a work place environment that supports professional nursing practice fosters effective conflict resolution strategies.

Description of the project

The two-hour courageous conversation workshop is a result of a fellowship project designed and implemented by a staff nurse to address the issues of conflict in his or her work environment. The workshop act as a platform to facilitate conversation regarding team functioning and support the creation of ideas on how to improve communications and team dynamics. The workshop is based on the principles of Appreciative Inquiry as well as the The Art of Possibility by Ben Zander. The Appreciative Inquiry fosters self-reflection, relationship building and open dialogue among nurses. The participants had the opportunity to identify ways in which they can work together to create a safe space for difficult conversations and support one another to engage in those conversations in a respectful and reverent way. This method has been tested previously in different interprofessional health settings (Ritcher, Ritchie & Marchionni 2009). The Art of Possibility provided nurses the opportunity to identify downward spiral conversation and possibility conversation. Both of these approaches enable nurses to find the courage to engage in solution based conversation and empowers them to develop strategies that will enhance the quality of their work environment. The facilitation of the workshop by a staff nurse was key to creating a safe and trusting environment for conversation and helped make the content more meaningful for participants.

The highly engaging workshop attracted the attention of the University Health Network Corporate Nursing and gained sponsorship by the Ontario Ministry of Health and Long-Term Care (MOHLTC), the Ontario Hospital Association (OHA), and the Ontario Nurses' Association (ONA). The primary goal was to address nurse conflict in the organization by promoting teamwork and developing staff capacity for systemic problem solving.

Conclusion

The Courageous Conversations Workshop was implemented from January to March 2012; over 50 nurse facilitators were trained and provided 150 workshops to 600 nursing staff across 27 patient care units at all four hospital sites (Toronto General Hospital, Toronto Western Hospital, Princess Margaret Hospital, and Toronto Rehabilitation Institute).

Content from the workshops discussions were collected and key themes were identified such as Respect; Fairness; Recognition; and Equality. Sub themes identified were: Workload and Staffing; Teamwork and Communication; Management and Leadership; Professionalism and Accountability; Education and Professional Development; Safe work Environments; Physical Environments.

During the development, implementation and evaluation of the Courageous Conversation Workshop, it became apparent that there was an interest to continue this project. The need to further engage nurses in solution-based conversations was highlighted as well as developing manager and unit leadership capacity specifically as it relates to communication and conflict management.

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Learning objectives

1. The learner will develop an understanding of how nurses' stories can be used to capture conflict, harassment and violence that affect the nurses day to day work experiences.
2. The learner through the use of courageous conversation will develop strategies that will empower nurses and other health care provider to collaborate in order to create a safe quality work environment.

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Global research activities against psychological aggression

Poster

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Focus: Research

Abstract

Introduction

Some previous studies expressed that Psychological aggression is a form of antisocial behavior taking another person under press through the use of fear, humiliation, and verbal or physical assaults. The major objective of current study is to determine the Global trend of scientific activities against Psychological aggression during a period of eleven years.

Method and materials

Databases of Science Citation Index (SCI-E) and Social Science Citation Index (SSCI) from Web of Science (WoS) were chosen to extract all papers indexed as a topic of Psychological aggression during a period of eleven years 2001-2011.

Results and conclusion

Analysis of data showed that a total number of 1,911 papers under a topic of Psychological Aggression were published in the journals that were indexed in SCI-E and SSCI during the period of study. In spite of some fluctuation throughout the period of study the study showed a slight growth of publications in the field of psychological Aggression. The study further showed that majority of publications came from English spoken countries. USA sharing 46% of global publication in the fields was the most productive country followed by Canada (7%), England (7%) and Australia (4%). University of Minnesota was the most prolific University followed by University of North Carolina, University of Suny Buffalo, and Harvard University. English consisting of 92% of total publications language was dominating language followed by Spanish (2%) and German (1%). Based on Bradford's scattering law the journal of Interpersonal Violence was the most prolific journal among core journals followed by Aggressive Behavior and Journal of Family Violence.

Learning objectives

1. The policy makers of countries should take the psychological Aggression more into consideration

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First do no harm: Implementing an ethical non-abusive approach to workplace violence training

Workshop

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Focus: Education and Training
Keywords: Ethical, frameworks, non-abusive, training, safety, learner

Background and context

Workplace violence (WPV) trainers, both internal and external, have to balance a number of competing demands and responsibilities in their work. They have to deliver the 'product' at a competitive price, meet the needs and expectations of the employer as well as deliver training appropriate to the identified needs of the staff. They also have a particular duty of care to the staff they train and indirectly to the service users. At the same time WPV trainers have an obligation to uphold the values, ethics, and codes of practice identified by their profession and in legislation and regulations governing their unique service settings.

While attempting to meet these competing demands some WPV trainers may not be aware of the ethical issues that arise or how to deal with them, a type of 'ethical blindness'. (Ward & Syversen 2009) An important aspect of this awareness is avoiding potentially abusive training practices that negatively effect trainees and ultimately the service users they care for. Ianinska & Garcia-Zamor (2006) note *"The choices adult education practitioners make in terms of who should learn, what should be learned, and whose goals should be prioritized have profound ethical ramifications."* (p. 14)

Some trainers may use potentially abusive training methods that include aggressive role-plays and simulated attacks, use of real weapons, loud noises and yelling or swearing, and simulated hostage situations. Other techniques may include showing graphic videos, spitting on trainees, pulling the hair of staff or using racial or gender taunts. Some trainers justify such techniques as necessary to 'toughen' up staff during training and to reflect the reality of the workplace. However the use of some abusive and fear based training methods may in fact be counterproductive to the learning experience and (re) traumatise training participants. (Black 2008) This may especially be the case with those trainees who have a previous history of trauma.

Such training 'techniques raise a number of key questions such as are they *".. ethical, appropriate or even useful? What does it do to those who [experience them] and how does it, if at all, 'enhance' the training experience? Do the learning 'ends' justify the 'traumatizing means'? If so under what circumstances are such methods are justifiable, if at all?"* (Bowie in press)

There are also other unethical approaches, perhaps not so obviously 'abusive' that need to be addressed. For example Colligan and Sinclair (1994) identified a number of unethical trainer behaviors. These include: a lack of professional development, violation of confidences, use of 'cure-all' programs, dishonesty regarding program outcomes, failure to give credit and finally, direct abuse of trainees.

Methodology

The purpose of this workshop is to first outline the key ethical frameworks applicable to WPV training. Then to identify the overt and covert worldview of the workshop participants. Building on this base some of the obvious and not so obvious ethical concerns that may arise in delivering such training will be highlighted. And then finally there will be presented a non-abusive training framework and resources that incorporate a dignity of risk approach (See Foundation 2005) to ethical practices in the development and presentation of WPV prevention and management skills. A number of interactive individual and small group exercises, scenario-building, case studies, brainstorming and mind mapping will be used to encourage maximum participation amongst the workshop participants.

This workshop has been developed from my extensive experience as a WPV trainer, through staff trainee and service user feedback, field observations as well as a detailed literature search. This approach has also involved collaborative research and scholarship with other leading academics and trainers in WPV. (See McKenna and Paterson 2006) The content is based on an upcoming publication Bowie. (in press)

The 7 foundations for ethical WPV training

The workshop is designed and presented using the7 foundations for ethical WPV training. (Bowie in press) These have been identified and developed from numerous sources including the National Staff Development and Training Association (NSTDA) code (Curry 2004), outstanding trainers, various codes of ethics and conduct, as well as action based research and practice wisdom. (Bowen 2011) What is unique here is the application of such ethical training concepts within the specific context of workplace violence training. Some of these concepts and

models may at first seem to be complex and irrelevant to the daily realities of WPV training but they are key to understanding not just the 'what' but also the 'why of ethical training.

These foundations are neither totally independent nor total sequential but interact and intertwine however they initially develop from the ethical frameworks. These foundations are

- Ethical frameworks,
- Learner centered approaches,
- Legal and professional responsibilities,
- Trauma informed principles,
- Responsibilities to staff trainees, service users and employer organizations,
- Trainer qualities,
- Programme development and delivery.

Implications

This workshop will help WPV trainers and their employers to identify what are potentially overt and covert abusive instructional methods and then in turn to develop more ethical and safe training policy and practice. Such identified issues should also stimulate research on the impact and transfer of learning using such non-abusive safety promoting training approaches. (Bowen 2011) These results also have major implications for training in the broader health and welfare services internationally.

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Learning objectives

1. Participants will identify key ethical guidelines applicable to WPV training.

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Improved nurse confidence and safety due to the Patient Aggression Management Project

Poster

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Focus: Education and Training

Abstract

To educate nurses regarding the implementation of an aggression management tool kit consisting of a risk assessment, management plan, computer alert flag and reporting form.

Learning objectives of the project

The education regarding the Patient Aggression Management (PAM) clinical tool kit includes the following objectives:

- Improve nurse confidence with managing aggessive patients,
- To increase the understanding of duty of care and mutual respect when caring for patients,
- To raise awareness of the PAM tool kit, that is available in clinical areas and on the intranet, when caring for aggressive patients,
- For nurses to become familiar with the formalised process of managing violent and aggressive patients.

Background and context

The Patient Aggression Management trial commenced on 15th December 2011 and concludes on 15th March 2012. The tool kit aims to assist in the management of all patient aggression throughout the hospital. The education aims to improve confidence amongst nurses on evaluating the aggression risk and implementing control measures on patients and visitors. The Best Practice Survey 2011, revealed a 5.5% decline in nurse confidence in managing verbal and physical violence.

Methodology

Clinical areas that received the tool kit were targeted for the education. 72 half hour presentations regarding the tool kit content and management strategies were held throughout SCGH. Over 720 nursing staff attended.

Outcomes

Of the 720 nurses educated regarding the trial. 97 people were surveyed. Responses were as follows:

- Nurses feel more confident in managing patient aggression and violence – 68.5% agree
- Nurses have a better understanding of duty of care and mutual respect when caring for patients – 80.4% agree,
- The PAM tool kit is an effective resource for managing a patient's aggression and violence – 82.4% agree,
- Nurses have an increased level of knowledge and understanding of the patient aggression management process – 88.7% agree.

Findings

The education increased the nurses understanding of the management responsibilities that are required when caring for patients that display aggression. This in turn enables the nurses to feel more confident when managing patient aggression. 80% of nurses surveyed, agreed to the outcome measures. The promotion of zero tolerance in previous years has created confusion and unrealistic expectations into the management of aggressive patients. Information regarding the outcome of the trial will be presented.

Implications for practice

This tool kit can be easily modified and customised to take into account the cultural, social and behavioural needs of patients and can be applied to other hospitals, clinics, and health care facilities.

The implementation of the education and PAM tool kit were not without their challenges. The Staff Development Nurse group were slow to take-up the promotion and revision of the tool kit due to restraints and workload. This meant that nurses that weren't educated were less likely to know about the resource. On occasions nurses were caring for patients without prior knowledge of the patient's security risk. This was due to nurse knowledge and time deficit regarding the resource.

Learning objectives

1. To demonstrate strategies to improve nurse confidence with managing violent and aggressive patients
2. To demonstrate strategies to improve consistency, communication and management of violent and aggressive patients.

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Cross pollination: Preventing and responding to violence in healthcare by adopting self-settling strategies

Paper

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Focus: Education and Training

Abstract

There are a variety of crisis intervention programs available that train staff response to violence in the workplace. The typical training program uses a combination of lecture (in de-escalation theory and interventions) and practice of physical interventions (PI) to transfer knowledge.

Participant evaluations of crisis intervention programs may indicate improved self-confidence from participants in their understanding of violence prevention/de-escalation. It is questionable whether this immediate self-rated confidence translates into improved practice and sophisticated application of de-escalation interventions. The literature in PI highlights the difficulty in properly assessing staff competence after training. It has been recommended that PI be trained to muscle automaticity (saturation), which may require ten-thousand repetitions (Stark & Bell, 2005)..

In practice, staff responses to violent events vary despite training. Some programs recognise that the human threat/fear response affects staff efficacy. Emerging body of literature supports the theory that people have limited ability to access memory, let alone formulate creative interventions. Few, if any, programs investigate or adopt therapeutic strategies (used by patients) to procure them for use by staff in crisis intervention events.

If we accept that the threat response hinders recollection and praxis, and we agree that the threat response affects de-escalation through non-verbal and para-verbal communication, then it would be pragmatic to include strategies to manage the threat response throughout crisis intervention training.

I propose that self-settling strategies employed in therapeutic interventions such as Dialectical Behaviour Therapy (Linehan, Bohus & Lynch, 2007) and Mindfulness (Siegel, 2007) can be adopted into crisis intervention training to help users maintain emotional modulation.

Modulation allows users to recall and put into practice the skills learned in crisis intervention programs. Furthermore, the emotional modulation of the staff is contagious and should help client to modulate.

Learning objectives

1. To demonstrate that self-settling should be interwoven into crisis intervention programs to improve efficacy.
2. To demonstrate that the pragmatic application of current therapeutic strategies will help to improve outcomes for current crisis intervention programs.

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Non acceptance of difference: A cause of violence in the health sector

Paper

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Focus: Education and Training

Introduction

The purpose of this conference is to discuss an age old problem. As Albert Einstein stated many years ago: *"We must learn to not only tolerate our differences. We must welcome them as a richness and diversity which can lead to true intelligence."* This reflection sums up the ideal we as health professionals should aspire to however as many of us are aware the ideal has far from been reached or become standard practice in our working lives.

Objective

The objective of this paper is to explore, primarily from a New Zealand perspective, with United Kingdom tales added in as support, discrimination against difference that so often leads to latent, overt and covert physical and psychosocial violence exercised upon competent health practitioners whose sexuality and chosen sexual expression has nothing to do with their competency in health service delivery.

Literature Review

The Nursing Council of New Zealand (2011) [NCNZ] has for twenty years required all students for registration in New Zealand to have demonstrated competency in the general subject of cultural safety .

Cultural safety education is delivered to students according to the Council's definition which is broad in its general application and extends beyond ethnic groups to include age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability.

The content of cultural safety education is focussed on the understanding of the self as a bearer of culture; the historical, social and political influences on health; and the development of relationships that engender trust and respect.

Two quotations from the NCNZ (2011) document *"Guidelines for Cultural Safety, the Treaty of Waitangi, and Maori Health in Nursing Education and Practice"* demonstrate this focus. Cultural safety is:

- *"The effective nursing practice of a person or family from another culture, and is determined by that person or family."*
- *"Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual."*

Rather than learning accessible aspects of different groups, as transcultural nursing theory and practice would have us undertake, a nurse who can understand his or her own culture and theory of power relations can be culturally safe in any context.

In the past, codes of ethics have stated that people should receive care without regard to their gender, race, culture or their economic, educational, or religious backgrounds. In New Zealand a great nurse educationalist and leader, Irihapeti Ramsden, created a quake proportion disturbance to the comfortableness of nursing practitioners when she stated that this was wrong and perpetuated the idea that nurses knew best and patients would meekly acquiesce to the commands and requests of the nurse. She said that codes of ethics should consider all patients regardful of their gender, race, or culture. She believed and taught that all nurses should regard all human beings with the taking into account of all that makes them unique (Ramsden, 2002).

If our students, and therefore our Registered Nurses, are required to demonstrate this acceptance, this difference in diversity, with patients, is it too much to ask that they also accept difference and diversity among their own?

It has been stated by a nurse speaking from her own experiences at a Nursing Council hearing that nurses do not respect difference and diversity and certainly do not respect difference and diversity among their own. Sadly this attitude and demonstration of perversity among all health professions has been noted by the author over a period of thirty plus years.

Method

This has been a longitudinal (and continuing) historiography and descriptive phenomenological study that has gathered information on the prevalence and degree of discrimination and the visitation of psychosocial violence

on and by health practitioners. From a thematic analysis of the many stories that were relayed to the lead researcher a common theme of discrimination, prejudice and frank hostility emerged.

Results and Discussion

As individuals we all have our own values, prejudices, likes and dislikes. As a beginning point in this discussion it is believed that if we have made that journey of self discovery, that journey where we are able to examine and dissect our prejudices, our hypocritical view points, our likes and dislikes; then we are more able to set these aside and nurse with care, our patient who exhibits difference and diversity from ourselves.

What is quite remarkable is that a cursory examination of the GLBT continuum discovers that society more or less accepts gay and lesbian persons today, bisexual persons are just never heard of, but the transgender individual is the lowest of the low and all latent, covert and overt homophobic behaviour in others is drawn out by this person.

We have struggled to understand why this might be and have eventually settled on one concept. In heterosexual attraction and expression, focus ultimately settles on the genitalia. For the transgender male to female person, to have surgically removed all those accruements of masculinity is not something the staunch heterosexual male can countenance. At least the gay man still has his *"equipment"* and is able to use it. For the transgender female to male person, removal of those sex objects, their breasts, so adored by most heterosexual males for no other reason than they no longer want them is a concept that cannot be understood. These acts that refute the concept that heterosexuality is the norm are reflected in the PhD thesis of Janice Raymond and published in her book *"The Transexual Empire"*. She asserts that gender reassignment surgery is the ultimate act of dominance of man over woman. This is a concept we do not agree with but may go some way to understanding the harsh acts of prejudice and discrimination visited upon some health professionals by others – all because of difference and diversity.

The transgender community in New Zealand was heartened to read the manuscript titled *"Diversity Appraisal Resource Guide"* issued by the United Kingdom Royal College of Nursing [RCN] some 10 years ago. The RCN definition of diversity as related to the workplace stated: *"a strategy to promote values, behaviour, and working practices which recognise the difference between people and thereby enhance staff motivation and performance and release potential, delivering improved performance to customers."* But it raised the question for us: *"Why?"* Why was such a guide required for employers and nurses in the UK health system? We are the health system's delivery vehicle for care – do we not care for our own? (RCN, 2002).

The New Zealand Labour Department featured and acknowledged the significant discrimination that transgender people face in day to day life, particularly in employment, in their document *"Transgender People at Work"*, released in 2011.

The New Zealand Human Rights Act 1993 prohibits discrimination on the grounds of gender identity, and the Employment Relations Act 2000, contained further provision that outlawed discrimination on grounds of gender identity.

The experiences of transgender nurses in New Zealand has seen them many times subjected to prejudice and hypocrisy of action by people who were judging the transsexual and not the nurse. Is it too idealistic to expect health professionals to be culturally competent? To be someone who is aware, or becomes aware, that being different from the norm can be marginalising and how this marginalisation can affect the seeking and receiving of healthcare; more importantly the delivery of health care; is quite a distasteful experience.

Violence in the health sector is so often, visited upon fellow health professional workers by other health professional workers who are openly homophobic and by their actions they cause increased levels of stress, anxiety and impaired work performance. This violence may be classified as bullying because it is persistent, and intentional. It may include overt aggression but more commonly includes subtle acts such as rumour-mongering, information withholding and exclusionary practices. Criticism, sabotage, undermining, intimidation, threats, violence, humiliation, excessive demands, inequitable rostering practices, blocked advancement opportunities, and the misuse of power have all been found by researchers from University of Sydney, Australia, School of Management in their studies into bullying in nursing. Their study found that gender choice and sexual identity are the basis for much of this bullying (Hutchinson, Vickers, Jackson, Wilkes, 2004).

It is the realisation that sexuality is an essential part of people's lives and therefore an issue for nursing and health professionals that has led to the consideration of the awful consequences that are visited upon those health professionals who do not fit the heterosexual norm of society by those who are prejudiced bigoted and hypocritical in their actions.

The Nursing Council of New Zealand with its cultural safety curriculum, the Royal College of Nursing document that deals with the discriminatory practices visited upon lesbian, gay, bisexual and transsexual nurses; added to the literature out of the United States of America inspired by the writings of Madeline Leininger on transcultural nursing has drawn attention to this problem in a most poignant way.

Before we look at some possible considerations to counter these discriminatory practices we will first recount from life and practice some actual examples.

1) After months of very difficult working conditions, and rank bullying, with complaints to the Director of Nursing that resulted in no action being taken this despairing email was received from a female registered transgender nurse: *"At the moment I have closed myself off completely from everything. Have been feeling quite suicidal lately, is so tempting to put everything in writing for the meeting (with her management) then jump off the cliff the day before. Seems the only way to get across just how it has made me feel."*
2) Another registered transgender nurse wrote stating: *"I started work but have since found out that my right to work on the ward was questioned by nurses before I started. When I found out the date for my surgery there was much interest from other staff members and I eventually told of the nature of the surgery I was being admitted for – I have regretted this ever since. Initially fellow nurses were helpful but I have become increasing isolated and subjected to verbal harassment."* She concludes a lengthy account with the information that the work situation following her surgery deteriorated to such an extent that she was unable to go back to work anywhere and was beginning a fight for her rights as a human being.
3) A competent English born and registered orthopaedic surgeon working overseas. Underwent gender reassignment surgery and following this returned to the UK to live and work only to encounter a refusal of the Royal College to register *"Her"* as a person capable of being recognised as an orthopaedic surgeon in the United Kingdom.
4) A Nurse Manager and a pre-operative transsexual, was confronted by a nursing supervisor who stated that *"I am leaving in two weeks but I'll get you out of here before I do"* – and she did. The supervisor did it in a most unethical way. The Nurse Manager looked after a mixed adult/child orthopadeic ward. A six bedded room contained six young girls of average age 12 to 15, all in Thomas Splints requiring bed rest cares. The supervisor tried to prime these patients to make complaints of sexual impropriety against the Nurse Manager. This nurse manager only became aware of these quite scurrilous efforts by a mother who came to her and asked what was going on. Knowing that there would only have had to have had one complaint, unproven and baseless as it would have been, made against her to have her Registration suspended, the Nurse Manager went to Administration within the hour and resigned her position of that unit effective immediately.

Our interest in these matters was more awakened with a New Zealand wide conference for teachers of cultural safety held in 2004. A very enlightening address from a tutor from the Lakes District Health Board School of Nursing (Rotorua for those of you who know NZ) asked the question: *"Why is it that our students go through their training and education and meet the Nursing Council Competencies and then abandon these teachings on graduation?"* It was her experience that new graduates did not demonstrate in their practice the principles of cultural safety which would have greatly reduced the psychological violence we see in health care delivery – visited upon patients and on our selves.

A great Australasian nurse, Professor Mary Chiarella, stated quite recently (ANZAHPE, 2012) that *"nursing was a three year exercise in bluff – you have to prove competency so you do."* This confirmed what our fellow tutor from Rotorua said – nursing students pass the competency to be able to sit their State Finals exam but then for all sorts of reasons, principally that of expediency, do not follow through with their teachings.

The Nursing Council New Zealand has four Domains of competence with a total of 21 competencies to be met and maintained before State Finals examinations can be sat.
Specifically Competency 1.5 requires that the student *"Practice in a manner that the client determines as being culturally safe"*. Note it is the client that makes the decision whether the health practitioner is safe – not the nurse. There are 7 aspects of this competency that require signing off and these include:

- Respecting each client's identity and right to hold personal beliefs, values and goals
- Reflects on her/his own practice and values that impact on nursing care in relation to the clients age, ethnicity, culture, beliefs, gender, sexual orientation and/or disability
- Avoids imposing prejudice on others and improves advocacy when prejudice is apparent

For the researchers in this study there is little doubt that steps to prevent discrimination and prejudicial actions and reduce the incidence of *"trashing our sisters"* as these actions have been described by Belinda Puetz, former editor of the Journal of Nursing Staff Development, begins at the top. Our employers and employing authorities are responsible for the culture of their workers.

There has been much written about the rights of gay and lesbian individuals to have their own values and beliefs accepted and they be allowed to live their lives and work in their chosen career without penalty for those beliefs. However when it comes to transgender persons all accepting ideals are thrown aside and all the latent and hidden homophobic traits are allowed out and visited upon them. The health professions and the health workforce is no protection from such verbal and psychosocial violence visited upon the transgender individual. It is our belief that gender identity and sexual identity should never be the grounds for any discriminatory practice however it would seem that being part of the *"caring"* professional workforce is not a guarantee that the individual practitioner will acknowledge their own discriminatory values and beliefs, and so knowing these be able to treat the patient or their colleague with respect and value.

Conclusion

This recounting of discrimination and psychosocial violence visited upon health professionals by other health professionals does not answer the question posed by the conference organisers: *"To present initiatives which respond to the problem . . ."* We can only hope our telling of these acts will make you think.

In trying to understand the anomaly between the ideals of care as typified by the health care delivery professional, and the practice of frank hostility, harassment, and discrimination has proved almost impossible to us. We can only think that because we are practitioners in a caring profession all other health professionals should be middle class heterosexuals and anyone who is not is fair game.

If you have another thought the researchers would be pleased to hear it. In the meantime we can only say that it well past the time that we followed the pronouncements of Irihapeti Ramsden and accepted all our fellows regardful of their race, gender identity, culture or their economic, educational and religious backgrounds. We acknowledge our own values and beliefs – we must acknowledge the right of our fellow health professionals to be diverse and different – without prejudice.

We close with a quotation from Leah Curtin, Professor of Nursing at Cincinnati University College of Nursing, who said that: *"Respect for others infers openness to discussion and debate in order to clarify differences of opinion, fact and intent; both are essential for healthy relationships."* And we add, essential to reduce the violence experienced in the health sector by those who present a difference and diversity from their fellows.

Acknowledgement

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Learning objectives

1. The education of health professionals along the lines of the NZ Nursing Council›s cultural safety guidelines would do much to reduce this aspect of violence within the health sector.
2. Health professionals need to accept the legitimacy of difference

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An organized team response to violence

Paper

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Focus: Education and Training
Keywords: Violence prevention, Organized Team Response

Introduction

This paper describes the conception of an Organized Team Response (OTR) to violence in Vancouver Island Health Authority (VIHA), highlights its evolvement to its current status and asserts the use of OTR as a major violence prevention strategy. The pilot project described in this paper highlights how the traditional use of code white teams (CWT) that use physical containment techniques is not always a safe option for health care staff to use. Situations involving violent behaviour require alternate and safe approaches for staff to use when assisting the person that is exhibiting violent behaviour. Research conducted during the pilot project was unable to produce alternate and safe approaches for staff to use in violent situations. This paper describes the work that was completed during the pilot project to address this gap, and specifies the findings and outcomes relating to OTR as an alternate and safe approach that staff may use when responding to violent situations and which enhances a Culture of Safety.

Background

Between 2007 and 2011, VIHA's Occupational Health & Safety Department (OH&S) undertook a pilot project (the project), which set out to implement a sustainable Code White Team (CWT) model of response to violent incidents in VIHA's acute care settings. The intent of the project was to establish a mechanism to reduce the number of violence related time-loss and medical-aid incidents. It was determined that prior to implementing CWTs, consistent foundational violence prevention education and training needs to be in place. As a result, the project's focus shifted to the development and implementation of a standardized Violence Prevention Curriculum (VPC).

The VPC consisted of 11 modules, ranging from basic violence prevention awareness to advanced CWT responses. Due to the modular design, VIHA program areas could opt to utilize those modules according to the assessed levels of violence as well as the learning needs of staff. As VPC implementation progressed, it challenged previously held assumptions about CWT responses, and as a result of extensive consultation, questions and doubts arose about the sustainability of the CWT methodology. The VPC implementation process included providing workshops to prepare VPC instructors throughout VIHA program areas.

Motivation/problem

As an alternate approach that staff can use to safely respond to violent incidents, OTR has many aspects that make it a viable proposition. The knowledge and skills that staff require to participate in OTR are grounded in VPC modules, resulting in initial OTR education and training being a maximum of two hours duration. This is in comparison to a full day of CWT education and training. The financial cost associated with releasing and replacing staff to attend OTR is therefore considerably less than CWT education and training.

Because of the need for staff to use techniques not exceeding verbal de-escalation, OTR practice drills are easily carried out, resulting in the maintenance of practice standards being a realistic proposition. As well, OTR capability is distinct for participating staff as in the event verbal de-escalation is ineffective, the next step that is supported by policy and procedure is for staff to contact security staff (where available), or the police. The appropriateness of OTR is supported by not expecting staff to use physical containment techniques while providing safe, competent and ethical care. Consequently, OTR enables the preservation of the therapeutic relationship between staff and patient.

Sustainability of a 24/7 CWT response involves many factors, including extensive planning, monitoring and evaluation; extensive education and training, together with the required infrastructure e.g. policy and procedure, staff support mechanisms and a CWT intervention reporting system. Associated with these factors is the need for strong leadership (on program/service and CWT intervention levels) to meet the high level of commitment and standards associated with staff using interventions that include physical containment techniques. Providing a CWT response also needs to acknowledge the potential for staff injuries arising from the use of physical containment techniques. In this respect, CWT sustainability has the constant challenge of meeting the safety needs of staff using CWT interventions to respond to violence and providing continuous quality patient care.

Methods

Because of the need for an alternate and safe form of team response, OTR was conceptualized, developed, implemented and evaluated. It was established that OTR refers to least restrictive staff interventions in teams of

two to five members. Assessment of the violent behaviour, team capability and the environment in which the incident occurs need to be taken into account to determine the number of staff involved in an OTR. OTR strategies involve the use of presence as a de-escalation tool, and unlike CWTs, do not use physical containment techniques.

An education and training package was developed to provide staff with the required preparation to safely participate in an OTR. This package was made up of a PowerPoint presentation, facilitator notes and OTR Practice Drill Guidelines. OTR education and training involved minimal lecture and mostly used demonstration and supervised practice of team interventions that reflected real scenarios. The intent of this approach was to prepare staff to complete OTR Practice Drills to develop effective team interventions in their program areas, and to keep their skills current.

The objectives of OTR education and training were to:
1. Understand the benefits of using team to prevent violence,
2. Assess the potential risks associated with using team to prevent violence,
3. Recognize specific cues to escalating emotions,
4. Understand levels of force and resistance,
5. Understand the use of most appropriate and least restrictive team responses,
6. Demonstrate the use of team to de-escalate verbal aggression.

A process that included specific steps was followed to assist project pilot sites to implement OTR.
These steps included:
1. OH&S staff meeting with managers, key stakeholders and VPC instructors to provide information about OTR implementation steps and infrastructure needs,
2. OH&S staff delivering initial OTR education, training and practice drills to staff (including existing VPC instructors),
3. VPC instructors co-facilitating OTR education, training and practice drills with support from OH&S staff,
4. Establishment of contact persons to provide liaison between pilot sites and OH&S,
5. OH&S staff providing on-going support for pilot site managers and VPC instructors.

OTR infrastructure included:
1. Documentation outlining the roles and responsibilities of participants, e.g. OTR Leader, Site Leadership, Clinical Quality Assurance, WorkSafeBC, etc.
2. A template of a code white response plan that could be adapted for OTR at pilot sites,
3. OTR policy and procedure,
4. A protocol outlining the steps that staff need to follow when responding to a code white call,
5. A communication plan for staff to follow when communicating with Security or Police,
6. A protocol outlining post-incident requirements, e.g. incident investigation, staff supports.

Evaluation of the project was based on its ongoing nature and built upon evaluations conducted at the end of the first year of VPC implementation. Evaluation involved the following approaches:
1. An End of Project Evaluation Survey,
2. A Summary of Participant Evaluations from OTR education and training at project pilot sites,
3. Violence-related quantitative data for VIHA and pilot sites.

Results and benefits

As a result of completing the project it was found that an OTR approach that uses least restrictive interventions is adequate for the majority of code white responses. Staff provided evidence that the team-based strategies used by OTRs allow them to safely, competently and ethically respond to violent incidents. Staff indicated familiarity and comfort with OTR roles and responsibilities in terms of them using interventions not exceeding verbal de-escalation, and understanding the extent of OTR capability, meaning that if de-escalation was ineffective, that they communicate with security staff or police.

The project generated qualitative and quantitative data that supports staff using OTRs to prevent or safely respond to violent incidents. In this respect, the reader is asked to take into account the limited scope of the feedback about the use of OTR at pilot sites and the VIHA-wide benefits associated with implementation of the VPC.

Three themes were identified from respondents' comments about OTR at project pilot sites:
1. The perceived high level of value of OTR training.
2. That OTR intervention should not exceed verbal de-escalation.
3. That the use of OTR should be emphasized to prevent violence.

Examples of respondents' comments about OTR included:

> *"I cannot express the value of … (OTR) training. I have responded to many Code Whites and have taken comfort knowing that my teammates are well trained and have all the skills they need to defuse the situation at hand".*

"The (OTR) approach process is highly effective at de-escalating violence and is the most important session of all the violence prevention education".

"I feel that the use of role playing was great. It gave the participants a unique opportunity to find out how the different levels of experience among the responders can make or break a violent or potentially violent situation".

Over the course of the project (2007-2011) the average number of days lost per violent incident decreased by 47% on a VIHA-wide basis, and by 42% at pilot sites. The costs associated with violent incident claims decreased by 63% on a VIHA-wide basis, and by 70% at pilot sites. Although these trends cannot be directly and definitively linked to the project, they do suggest that VIHA's continued diligence in addressing violence related issues is positively impacting its safety culture.

Analysis of feedback about regularly scheduled OTR practice drills revealed a number of themes:
1. Consolidation of knowledge and skills learned in VPC learning modules and initial OTR training
2. Further emphasis of the use of team intervention strategies
3. Provision of practice opportunities of de-escalation, engagement and disengagement techniques
4. Reinforcement of team roles and responsibilities in effective team interventions
5. The appropriateness of participatory learning (despite initial skepticism of role plays)

The conclusion of the project included the following recommendations:
1. VIHA should continue to support the delivery and expansion of the VPC and OTR education and training authority-wide. In addition to recognizing the safety needs of all VIHA staff, the VPC and OTR align education and training with a corresponding level of risk, provide a safe no hands on approach for all participants, and further enhance the use of teams already in place within the healthcare setting.
2. Each Program/Portfolio should adopt, and where necessary, customize the VPC and OTR education and training to meet the learning needs of staff, and ensure safe, competent and ethical care of patients.
3. The Provincial VPC should be adopted and integrated as part of VIHA's violence prevention strategies. This will assist in enhancing and sustaining the VIHA VPC, and build on the findings of this project by further developing the criteria by which sites are considered to be able to sustain 24/7 CWT response capability.

Conclusion

This work has resulted in the development of OTR as a safe and appropriate form of code white response to violence, which uses team presence and verbal de-escalation to maintain the safety of all involved in the situation. The benefits of OTR include staff confidence in their expected roles and responsibilities and in the need for completing practice drills to enhance their knowledge and skills. Staff working together in OTRs reinforces the benefits of staff working in ward or department-based teams and is congruent with the notion that 'staff that work together in teams are more likely to be safe together'.
This work can be transferred and applied in any health care setting where teams exist (where 'team' is two or more staff).

Acknowledgments

VIHA Staff from Campbell River District Hospital, Cowichan District Hospital, Nanaimo Regional District Hospital, Mental Health and Addiction Services, Seven Oaks Tertiary Mental Health Facility, Occupational Health and Safety Department, Library Services, Leadership, Regional Violence Prevention Committee (Unions and Management), and WorkSafeBC,

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Learning objectives

1. To demonstrate the Organized Team Response as a safe, appropriate and ethical form of team intervention to violent incidents.
2. To demonstrate the appropriateness of a continuous learning model to support staff learning needs to safely participate in OTR.

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Elder abuse: Recognize, reveal and deal

Paper

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Focus: Education and Training
Keywords: Long term care facilities, elder abuse

Background

The World Health Organization, as well as the Government of Canada through its National Seniors Council, has defined elder abuse as a single or repeated act, or lack of appropriate action, occurring in any relationship where there is an expectation of trust, which causes harm or distress to an older adult (Krug, Dahlberg, Mercy, Zwi & Lozano, 2002; National Seniors Council, 2007). Elder abuse may include physical, psychological and sexual abuse, financial exploitation, passive or active neglect, and violation of rights (Payne & Burke-Fletcher, 2005). A broad definition of abuse in long-term care facilities also includes violations of care, such as lack of privacy, de-individualization, infantilization and disrespectful behaviours, which impair the quality of life of the older adult (Lowenstein, 1999).

Anecdotal evidence suggests that elder abuse and neglect in long-term care facilities is global and widespread (Hawes, 2002; Krug, Dahlberg, Mercy, Zwi & Lozano, 2002). Adults in long-term care settings are particularly vulnerable as they are isolated from community and familial supports, and may be affected by co-morbidities that can influence their response to abuse. A recent survey of family violence in Canada found that 7% of older adults had experienced some form of emotional abuse, 1% financial abuse, and 1% physical abuse or sexual assault, at the hands of children, caregivers or partners during the previous five years (Division of Aging and Seniors, 2006).

In Canada, since 1981, the proportion of adults aged 65 or older living in health care institutions has remained fairly stable at around 7% (Public Health Agency of Canada, 2001; Statistics Canada, 2007). However, over the same period, as the elderly population increased, the actual number living in health care institutions rose from about 173,000 to more than 263,000 (Ramage-Morin, 2005, p. 47). *"It is estimated that the number of beds required in long-term health care facilities could rise from 184,300 in 1996/97 to over 565,000 in 2031"* (Trottier, Martel, Houle, Berthelot & Légaré, et al., 2000, p. 49).

Long-term care facilities in the Canadian health care system provide living accommodation for people who require on-site delivery of 24/7 supervised care, including professional health services, personal care and services, e.g. meals, laundry, and housekeeping. Long-term facility care is not publicly funded. It is regulated by provincial and territorial legislation, and is not consistent across Canada regarding policies, practices, and educational support for staff.

Resources to educate and support direct care service providers are needed to empower staff to identify and report suspected incidences of abuse and neglect in long-term care facilities, improve the quality of their work life, minimize organizational contributors to elder abuse and neglect, and ultimately provide quality care with dignity and respect.

The PEACE project

The Canadian Nurses Association (CNA), in partnership with the Registered Nurses' Association of Ontario (RNAO), led a two-year pan-Canadian project to increase direct care providers' awareness and understanding of elder abuse. The Promoting Awareness of Elder Abuse in Long-term Care, also known as the Prevention of Elder Abuse Centres of Excellence (PEACE) project, was funded by the Government of Canada's New Horizons for Seniors Program, Federal Elder Abuse Initiative.

Objectives

The intent of this project was to increase direct care service providers' (nurses, unregulated care providers, and other service providers) awareness of the important role they play in addressing elder abuse. This was achieved by providing them with resources to help them recognize elder abuse situations (both potential and actual) and by promoting interventions to reduce its occurrence. The anticipated project outcomes were to enhance the respect for and dignity of older adults, which are consistent with the *"delivery of safe, compassionate, competent and ethical care"* according to the Canadian Nurses Association (CNA, 2008, p. 2; CNA, 2009).

Process

The PEACE project was directed by a Pan-Canadian Advisory Committee with key stakeholder representatives, including from the Canadian Gerontological Nursing Association, Forensic Nursing Society of Canada, Canadian Healthcare Association, Canadian Council for Practical Nurse Regulators, and Registered Psychiatric Nurses of Canada, as well as a representative police constable responsible for elder services.

Specific strategies included:

- compilation of existing elder abuse awareness resources;

- development of an evidence-based curriculum for direct care service providers;
- selection of ten PEACE sites across Canada with registered nurse (RN) coordinators to deliver the curriculum;
- provision of ongoing support for RN coordinators; and
- completion of an evaluation process.

The RN coordinators led and promoted this important work at their sites and through their networks. The project team (RNAO and CNA staff, PEACE coordinators and Advisory Committee members) developed a curriculum divided into five modules:

- **Understanding Elder Abuse** – Participants learn why elder abuse is an important issue, review definitions and different types of elder abuse and mistreatment.
- **Recognizing Elder Abuse** – Participants learn about
  - red flags (signs, symptoms and situations) of various forms of elder abuse and maltreatment; as well as
  - general characteristics of the abuser and the abused.
- **Learning the Law** – Participants learn about legislation pertaining to elder abuse in Canada, with a focus on the specific laws of their respective jurisdiction. The reporting procedures for suspected and observed cases of abuse differ in each province and territory.
- **Intervention Strategies** – Participants learn about resident-centered care and therapeutic relationships as strategies to prevent elder abuse; and learn to develop and discuss strategies for intervening in and reporting situations of suspected abuse, while identifying next-step intervention strategies.
- **Healthy Work Environments** – Participants explore the definition of a healthy work environment, make the connection between healthy work environments and abuse, learn about workplace factors that contribute to abuse, and consider how their work environment could be improved.

The curriculum was implemented at the ten10 PEACE sites. It was delivered in different formats and timeframes depending on the practices at each site. Examples include:

- 20 minute face to face educational sessions;
- on line modules; and
- content provided in American Sign Language.

Despite the different delivery styles; it was important to ensure consistency in the approach of the on-site PEACE coordinators. Consistency was facilitated by a four day face-to-face orientation session prior to the start of the delivery of the curriculum at their respective sites. To promote networking with and provide support to the PEACE coordinators, monthly knowledge exchange teleconferences were held through the duration of the project. This allowed the coordinators to share experiences and discuss challenges. Monthly reports were also submitted to the project manager to monitor the various activities at each site and to intervene with support, if needed. To increase the reach of the curriculum, the PEACE coordinators also disseminated it though their networks, which included other long-term care facilities in their regions, colleges and universities with nursing programs, interested members of the public, and other health and human service colleagues through conference presentations.

The PEACE project culminated in the release of the knowledge feature on the CNA NurseONE.ca portal, Elder Abuse: Recognize, Reveal and Deal. This comprehensive online resource includes:

- expert contributions;
- two webliographies: Elder Abuse Policy and Practice and Elder Abuse Research;
- new educational resources (curriculum with facilitators' guide);
- key Canadian and international resources; and
- a Community of Practice (online resource that connects interested stakeholders for a common purpose).

Elder Abuse: Recognize, Reveal and Deal is accessible from nurseone.ca and cna-aiic.ca. It is available in both English and French, reflecting Canada's bilingual nature.

Evaluation

Over nine hundred participants from the 10 PEACE sites completed the baseline, three, and six month post quantitative designed surveys. In addition, qualitative data was obtained through focus groups held with the RN coordinators and other key stakeholders (e.g. directors of care) at each site.

Ethics approval was received from the University of Calgary (Alberta, Canada). While a necessary requirement for research studies, obtaining this approval demonstrated that the PEACE project team promoted the rights of older adults – and as previously articulated, violation of rights is in itself a form of abuse.

Evaluation should not be considered in isolation and the following findings demonstrate evidence that informs nursing practice in a variety of ways:

- Direct care service providers were more aware, empowered, and able to discuss suspected incidents of abuse;
- Enhanced RN job satisfaction and leadership skills;
- Overwhelming participation in the educational sessions from all levels of staff at the PEACE sites;
- Creative dissemination of elder abuse information;
- Identification that quality of practice environment is a key factor when addressing elder abuse (i.e., staff education, staff stress, manager support, employer policies);
- Managerial support for elder abuse education contributes to the reduction of such incidences for residents; and
- Great thirst for elder abuse resources from nurses and other care providers.

Implications for Health Care Practice

The findings of the PEACE project can be applied to and inform similar elder abuse initiatives in other health sectors (including home, community, and acute care hospital settings) and can provide a basis for the development and implementation of best practice guidelines. Implications include:
Implications for practice: 1) Education of and support for direct care service providers about elder abuse is critical; and 2) Healthy practice environments support staff to provide quality resident care with respect and dignity.
Implication for education: 1) Incorporate elder abuse recognition and intervention strategies into entry-level curriculum for health providers.
Implications for management: 1) Support from all management levels to address elder abuse will enhance success in preventing abuse and minimizing harm to residents; 2) Development and dissemination of clear organizational policies (identification and reporting processes) will provide direction and support for staff to address elder abuse; 3) The diverse and complex nature of elder abuse requires an interdisciplinary approach; and 4) Nurses, who are highly trusted by the Canadian public and who work in settings across the continuum of care, are well positioned to provide education about elder abuse and to support staff with activities that reduce the occurrence of this abuse.

Where will the future take us?

This project has substantially contributed to the understanding of direct care nurses and other staff working in long-term care facilities to recognize, reveal and deal with the challenge of elder abuse. However, there remains substantial work to be done to alleviate it.

The Government of Canada has recently announced funding for a national prevalence study on elder abuse in Canada. While the thrust of the work will be focused on those older adults residing in the community, there will be a specific section of the study focusing on those older adults who live in long-term care facilities. In addition, the Registered Nurses' Association of Ontario has recently received federal funding for the development of a Best Practice Guideline on elder abuse.

Acknowledgements

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Learning objectives

1. Learners will be able to identify factors that empower staff to address elder abuse.
2. Learners will be able to apply project findings to inform similar initiatives in their practice settings.

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Prevention strategies of horizontal violence among graduate nurses

Poster

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Focus: Education and Training

Abstract

Background

Horizontal violence becomes a concern of the nursing profession. Research supported that graduate nurses tend to be more vulnerable to horizontal violence that brings negative impact on them. Effective prevention strategies are necessary to improve the current situation. The purpose of this study is to identify the prevention strategies to prevent and protect graduate nurses from horizontal violence during clinical practices.

Methodology

Literature was searched through databases (PubMed, MEDLINE, CINAHL). Articles published from 2002 to 2012 were included. Keywords such as 'horizontal violence', 'prevention', 'graduate nurse' and 'lateral violence' were used. The prevention strategies of horizontal violence among graduate nurses were identified and categorized.

Findings

The prevention strategies were identified and categorized as follows.
Top-down approach: Top-down approach was suggested in order to implement a horizontal violence prevention program successfully. Support from management and nursing staff was essential. Institution should have a clear policy on reporting, enforcing and monitoring on horizontal violence incident. With heightening the awareness, it would help to minimize the occurrence of horizontal violence.
Mentoring and investigation system: Mentoring system offered support for building up one's skill and competency and also offered a communication channel. When incident was reported, investigation would be initiated. Both systems not only help in enforcing the horizontal violence but also facilitate in follow up action.
Role model: Nursing staff should be role model to reinforce effective communication that would influence graduate nurses perception on professional image and behavior in the future. Information of general communication skill should be reinforced. An open atmosphere of communication should also be empathized so as to promote the desire of communication. Adequate and effective communication could minimize the occurrence of medical incidents.
Education: Education sessions were identified to be helpful to eliminate horizontal violence. The content should include policy introduction, strategies that enhance positive working relationship, information about supportive service and communication skills. Communication matrix about reporting was essential to eliminate further incident and protect graduate nurse by initiating appropriate follow up action.
Empowerment: Graduate nurses were perceived as weak and with the lowest status in the hierarchy of nursing profession. Moreover, nursing was considered as a powerless group in healthcare. Empowerment would decrease tendency to become the oppressed one and also improved the reporting rate of incident. Interactive workshop providing a controlled environment for graduate nurse to identify early sign of disruptive behavior and return demonstrate effective communication skill and confrontation skill were suggested. Cognitive rehearsal was also claimed as useful for address disruptive behavior.

Implications

Horizontal violence significantly affects the professional development of graduate nurse. In global shortage of nursing manpower, there is critical need to protect and advocate 'our youngs'. By introducing horizontal violence prevention strategies, graduate nurse will have a better adaptation in role transition from learner to professional.

Learning objectives

1. To identify the prevention strategies to prevent and protect graduate nurses from horizontal violence during clinical practices.

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Implementation of gentle persuasive approaches into an acute care setting

Poster

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Focus: Education and Training

Abstract

Hamilton Health Sciences is a multi site 1000 bed academic tertiary care center in Hamilton Ontario canada. Older adults represent 66% of admissions to medical surgical adult wards. Occurrence reporting in 2009 showed that 20% of incidents were related to patient behaviour. A staff survey of burden of care for older adults in 2009 reported that 60% of staff were disturbed by older adults behaviour on a daily basis. Delirium and dementia are common conditions that underlie many of responsive behaviours in older adults that staff experience as agitated or aggressive. Gentle Persuasive Approaches (GPA) in Dementia Care is a one-day workshop that was developed, implemented and evaluated in long term and complex care settings in Ontario in 2004. The overall goal of this evidence-based curriculum is to 'use a person-centred, compassionate and gentle persuasive approach to respond respectfully, and with confidence and skill to challenging behaviours associated with dementia'. Over 46,000 staff in 700 settings across Canada have been trained by 800+ certified GPA coaches.

The objective of this project was to implement and evaluate GPA in acute care settings. Pre and post GPA intervention baseline assessments of relevant patient occurrences, fall rates, restraint use and patient and family complaints were evaluated. Using the combined expertise of a Chief of Nursing Practice, a Nurse Researcher, Advanced Practice Nurses and 19 interdisciplinary staff who became certified coaches, the GPA curriculum was delivered to over 600 staff members on the medical, surgical, ICU, CCU and emergency departments of one acute care hospital site. Approximately 200 staff from another site in the same hospital system who did not receive the training served as the comparison group. A survey to measure staff's perceived level of confidence related to managing responsive behaviours competently was administered before and after the workshop, and after 6 weeks with staff in both the intervention and the comparison groups. Other evaluation methods included focus group s, injury reports, incident reports on aggressive behaviour, rates of code whites and code yellows and restraint use for both the intervention and comparison sites. A quasi-experimental mixed methodology was used to evaluate the changes with the comparator and intervention sites. Within a one year time frame, all clinical and non-clinical staff received GPA education at a single acute tertiary site with progressing educational intervention at the second (original comparator site), based on promising change in care delivery and practice outcomes. Approximately 200 staff from another site in the same hospital system who did not receive the training served as the comparison group. A survey to measure staff's perceived level of confidence related to managing responsive behaviours competently was administered before and after the workshop, and after 6 weeks with staff in both the intervention and the comparison groups. Other evaluation methods included focus groups, injury reports, incident reports on aggressive behaviour, rates of code whites(violent situation) and code yellows(missing patient) and restraint use for both the intervention and comparison sites. Staff immediately apply and utilize this education in the clinical setting, as it provides an improved patient and staff experience, and is highly effective in de-escalating agitated behaviors associated with dementia and delirium. Evidenced based education can be highly effective in improving the patient and staff experience, when it is provided in an interactive and engaging manner. Knowledge translation can be achieved when education is provided to clinical and non-clinical teams providing direct and indirect patient care. Middle and senior management support is integral to the support of individual and organizational accountability.

Learning objectives

1. Develop an understanding of the care competencies and environmental conditions needed to prevent and deescalate agitation in hospitalized patients with dementia.
2. Apply a knowledge translation model to guide the process of introducing evidence based practice from long term care to the acute setting.

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Raising awareness of workplace bullying and processes available to address it

Poster

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Focus: Education and Training

Abstract

Background

A growing collection of research shows that bullying is prevalent in healthcare workplaces. Exposure to workplace bullying can negatively affect the health of targeted individuals, their co-workers, and their family. Bullying also impacts the work environment, reducing team communication, job satisfaction, morale, and affecting patient care. It is associated with nurses leaving their job or the nursing profession. Raising awareness about workplace bullying, and the processes available to address it, is a step in creating respectful workplaces.

Methodology

In 2012, the British Columbia Nurses Union (BCNU), a provincial union that represents about 32,000 nurses and allied healthcare workers, created a set of learning tools to engage healthcare workers in dialogue and activities about workplace bullying. Tools were based on resource materials from the BCNU Workshop Building Dignity, and current publications. Tools were launched in conjunction with Pink Shirt Day, an annual day designated in British Columbia as an opportunity for citizens to raise awareness about bullying in any setting, including schools, workplaces, and over the internet. A summary of each tool is provided below.

Bulletin board kit: The kit consisted of a series of seven visually appealing one-page posters for display at worksites. Each poster focused on one informational element, including the definition of and facts about bullying, a checklist titled Could it be you, processes to address workplace bullying, and links to additional resources. Posters were displayed in a variety of places, including unit bulletin boards, and information tables.

Power point presentation: A five-minute power point presentation reflecting the key messages from the posters was created, and included speaker notes. The presentation was available to assist worksite stewards with both formal presentations and one-to-one or small group discussions. Give-aways with Promoting a Bully Free Zone messaging were provided to stewards as engagement tools.

E-bulletin: A one-page e-bulletin, posted on the BCNU website and emailed to all BCNU members, summarized the core messages from the posters, and listed key processes members could use to address workplace bullying. It also provided links to additional resources.

Findings and implications for practice

Feedback from stewards indicated that all of the tools were well received and used in a variety of ways at healthcare worksites across BC. Stewards used the tools as a catalyst for dialogue, and organized pink themed activities. Uptake of the tools continued beyond the Pink Shirt Day, with requests from worksites with ongoing anti-bullying endeavors. Additional resources, including an online component, are under development for 2013. This initiative continues to demonstrate successful application of these simple, low cost tools that were produced, distributed, and used with relative ease.

Learning objectives

1. To describe a set of learning tools created to engage healthcare workers in dialogue and activities surrounding workplace bullying.

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Building capacity: Tools to engage healthcare workers in workplace violence prevention dialogue and learning activities

Poster

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Focus: Education and Training

Abstract

Background

Violence is a leading cause of injury to healthcare workers in the province of British Columbia (BC), Canada. Between 2006 and 2010, over 700 claims for nurses who were injured and disabled from work due to violent incidents were accepted by the BC Workers Compensation Board. Knowledge about risk factors for violence in healthcare, strategies for prevention, and avenues for seeking assistance are key components of a violence prevention program.

Methodology

In 2012, the British Columbia Nurses Union (BCNU), a provincial union that represents about 32,000 nurses and allied healthcare workers, created a set of learning tools to engage healthcare workers in dialogue and other learning activities targeting the above mentioned knowledge pathways. The content was based on BC Healthcares standardized Provincial Violence Prevention Training Curriculum. The tools used a combination of static information sources (paper and electronic), online interaction, and resources to support formal presentations and small group or one-to-one interaction. The tools were launched in conjunction with North American Occupational Safety and Health Week (NAOSH). The intent was to support stewards, Joint Occupational Health and Safety Committees (JOHSC), and BCNU members with member driven NAOSH week activities aimed at worksite violence prevention awareness. A summary of each tool is provided below.

Bulletin board kit: The kit consisted of a series of seven visually captivating one-page posters for display at worksites. Each poster focused on one informational element, such as statistics about violence in healthcare, risk factors, prevention measures, worksite violence prevention policy, reporting procedures, and how to contact the workplace JOHSC. Posters were displayed in a variety of high traffic areas.

Online contest: The online interactive Violence Prevention Challenge was composed of six statements about violence prevention that participants were asked to identify as Myth or Truth. Answers linked to the key messages on the posters. Participants could enter to win draw prizes.

Power point presentation: A five-minute power point presentation reflecting the key messages from the posters was created, and included speaker notes. The presentation was available to assist worksite stewards with formal presentations and with one-to-one or small group discussions. Give-aways with violence prevention messaging were provided to stewards as engagement tools.

E-bulletin: A one-page e-bulletin, posted on the BCNU website and emailed to all BCNU members, summarized the core messages from the posters, and listed key actions members could take to reduce the risk of violence at their worksite. It prompted members to participate in worksite NAOSH Week activities, and linked them to the online contest.

Findings and implications for practice

Feedback from stewards indicated that all of the tools were well received and used in a variety of ways at healthcare worksites across BC. Stewards reported that the tools encouraged learning, were a catalyst for dialogue, and assisted them with processes to address violence concerns at their workplaces. Stewards reported additional positive outcomes such as increased team work and collaboration with JOHSCs, and steward teams. The initiative demonstrated successful application of simple, low cost tools that were straightforward to produce, distribute, and use.

Learning objectives

To describe a set of learning tools created to engage healthcare workers in dialogue and learning activities about risk factors for violence in healthcare, strategies for prevention, and avenues for seeking assistance.

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Health and safety in action, Provincial Violence Prevention Program Initiative

Workshop

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Focus: Education and Training
Keywords: Violence prevention education, e-learning, classroom sessions, facilitator workshops

Introduction

The Provincial Violence Prevention Initiative was one of four major health and safety initiatives which were part of a provincial program called Health and Safety In Action (HSIA). HSIA was facilitated by the Health Employers Association of BC (HEABC), in partnership with WorkSafeBC, Healthcare Benefit Trust, the BC health authorities and Providence Healthcare.

Funding for HSIA came from an acute care contribution surplus identified by WorkSafeBC. The intent of the HSIA projects was to lead to improvements in employee health and safety which will ultimately result in improvements in patient care and services. This provincial approach to violence prevention is an opportunity to standardize education and training, to improve violence prevention practices and to influence the culture of safety and mutual respect for both patients and health care workers.

Background

From 2009 to 2011 BC healthcare partners embarked on an ambitious and significant undertaking to address the issue of violence in the workplace and to promote a standard for violence prevention education and training. The health authorities, health care unions, WorkSafeBC and the former Occupational Agency for Healthcare in BC (OHSAH), collaborated to develop a *"made in BC"*, provincial violence prevention curriculum (PVPC). The PVPC consists of online educational modules and supporting classroom modules. The online modules were completed in 2010 and the classroom modules in 2011.

Provincial Violence Prevention Curriculum Overview

The provincial violence prevention curriculum consists of 8 foundational online or e-learning modules. They are:

- E-Learning Modules
- Overview
- Recognizing and Responding to Risk
- Interventions in Acute, Residential and Community Care (3a, 3b and 3c)
- Communication Basics
- De-escalation Skills
- Responding to Physical Violence
- Post Incident Response
- Behavioural Care Planning for Violence Prevention.

Four of these modules can be supplemented with interactive classroom-based training. Not all workers need every module. The provincial curriculum development team and initiative team have provided guidelines on which employees require which modules. One health authority has added a ninth module with health authority specific information.

Classroom Modules

- Communication Basics for Health Care
- De-escalation Skills for Health Care
- Personal Safety Strategies for Violence Prevention
- Behavioural Care Planning for Violence Prevention

A fifth module, Advanced Team Response (ATR) for Health Care was originally planned to be part of this initiative. Due to the scope, complexity and compressed timeline for the initiative the ATR and Code White team response were not included.

Initiative Overview

The participating health authorities in the Provincial Violence Prevention Initiative included Fraser Health, Interior Health, Northern Health, Providence Health Care, Provincial Health, Vancouver Coastal Health and Vancouver Island Health. Three pilot sites were chosen from each health authority with the exception of

Providence Healthcare and Provincial Health which each had one. A total of 17 pilot sites were involved. The sites were a mix of acute care, residential and community facilities.

The initiative team consisted of an Initiative Sponsor, Initiative Manager and 6 initiative leads. Initiative leads were chosen for Fraser Health, Interior Health, Northern Health, Vancouver Coastal Health and Vancouver Island Health. Providence Healthcare and the Provincial Health Authority shared an initiative lead.

Scope

To achieve the goal of identifying, developing and implementing best practices for violence prevention the main objectives were to:

- Evaluate the current state of violence prevention programs.
- Identify gaps.
- Identify health authority best practices and conduct a literature review.
- Implement the Provincial Violence Prevention Curriculum at selected pilot sites.
- Develop a Facilitator development and support program.
- Evaluate the curriculum implementation and the initiative.

Initiative Methodology

The initiative team began with completing the current state assessment and gap analysis. The assessment format was based on the OHSAH document, *"Elements of a Best Practice Violence Prevention Program for BC Healthcare"*. The assessment and gap analysis provided the basis for identifying and sharing current health authority best practices in violence prevention and identifying gaps in health authority violence prevention programs. Once the assessment was completed, the initiative team focused on developing an evaluation framework for the components of the initiative. Considerable time was also spent developing a provincial violence prevention facilitator development and support program including a facilitator workshop, teaching plans and tools.

Next, initiative leads worked with their health authority partners to identify and choose pilot sites. Once pilot sites were confirmed the general plan was to complete an implementation plan, communicate the pilots, distribute the pre-pilot perception survey, schedule focus group sessions, identify facilitator recruits, hold facilitator workshops, schedule and conduct classroom sessions, distribute post pilot surveys, evaluate the results and report out.

Results

The perception survey, with the exception of one question, showed statistically significant improvements in employee responses. Respondents indicated that they felt their safety was as important as patient safety and that they were encouraged to work safely. Health authority leaders were seen as committed to safety. However in the pre-pilot survey only 49% indicated that they had used violence prevention policies and procedures, only 54% indicated they had received training in violence prevention and that they always checked for potential violence from clients. Just 55% indicated that they always follow violence prevention procedures. The post survey results were more encouraging with 95% reporting they had received training and 81% stating that they always follow violence prevention procedures.

Pilot Participation.

The level of participation in the initiative was generally very good. Over 800 employees began the initiative and 734 completed the e-learning and 683 participated in the classroom sessions.

E-Learning

The pilot sites completed the e-learning modules in a variety of ways. Some participants were asked to do the modules at work. In some cases but not all, extra staff was brought in so participants could complete the modules. Other participants were asked to complete the modules when they had down time. Another method was to book a computer lab and have employees complete the modules in a group. Finally, some employees were asked to complete the modules at home or another time and location of their choice. The participants completed a time card to record the length of time it took per module as well as to document the hours they were to be paid for.

The evaluation results and feedback from pilot participants was very positive. Even with reported frustrations related to the e-learning, 87% agreed or strongly agreed the modules were relevant and useful. While there was not an overwhelming result for the best option for completing the modules, completing them at home or in a location and time of convenience was the most favourable option at 45%, in a scheduled computer lab was the next favourable at 40% and the least favourable option was at work on the unit at 35%. Over 75% of respondents were able to complete the individual modules in 30 minutes or less.

Classroom training

The classroom modules were designed so they could be delivered individually or combined. Each of the modules were expected to take up to two hours but can take more or less depending on the needs of the participants. The classroom modules contain similar information to the e-learning modules and were planned to build on the knowledge gained with participatory exercises and various methods of facilitation such as videos, role plays, demonstrations and practice. The pilots differed in their approach to delivering the classroom modules. One health authority, Fraser Health, delivered 3 modules in a four hour session; others delivered 4 modules over a 7.5 hour day or split up the modules and offered them in 2 to 4 hour time frames. The classroom modules were facilitated by the initiative leads, health authority violence prevention staff and by facilitators from the pilot sites who attended the facilitator workshop. The classroom evaluation focused on the learning objectives for each module as well as the facilitator's ability and relevance of the material.

The classroom session evaluations were very positive. Over 91% agreed or strongly agreed the modules were relevant to their needs and over 95% rated the program very highly with a mean rating of 4.6 out of 5.0. The number of comments expressing thanks or calling the program excellent, practical and awesome was very unusual for an education and training program. There was a general theme of appreciation for the program and the opportunity to participate in the pilot.

Facilitator Workshop

There were 7 facilitator workshops held during the initiative. Each workshop was a three day session. Facilitators were provided an overview of the provincial initiative, introduced to the curriculum and given an opportunity to present a portion of the curriculum and to lead small group sessions for the personal safety strategies. The participants were asked to evaluate each day of the workshop as well as each component of the curriculum. They were also asked to provide feedback on the materials, exercises and overall relevance of the PVPC and workshop. The participants varied in their experience, occupation and facilitation skills. The workshop changed and evolved from the first session to the last. Participant feedback was a major driver of that evolution. The workshops were generally a very positive experience and were energetic, engaging and fun. Of the participants, 93% agreed or strongly agreed the workshop was relevant to their needs as violence prevention facilitators and 95% reported that the workshop was an enjoyable learning experience. Over 94% rated the overall workshop very highly with an average score of 4.5 out of 5.0. The Facilitator workshop materials are available as a complete package and are a valuable addition to the PVPC.

Manager Survey

Managers of the pilot sites were asked to complete a pre and post pilot survey. They were asked 6 general questions about their perception of how the initiative would impact workers knowledge and skills around violence prevention as well as how it might impact workplace injuries. Managers were also asked about their perception of senior level support for violence prevention programs. Managers overwhelming stated that their executive team strongly supported violence prevention programs. However, most also stated that they did not have an assigned budget for violence prevention, that they had difficulty releasing or replacing staff for the training and that there were challenges scheduling workers for training. Other responses indicated that workload, both for staff and for managers, was an issue. According to the pre and post survey results, the time frame of the initiative was not long enough to assess whether there was or would be a reduction in the severity of worker injuries as a result of training. Finally, availability of computers and ease of obtaining records of training were additional challenges.

The initiative had other positive benefits. Not least among them was increased awareness of violence and prevention program requirements. The PVPC meets the requirements of the Recommended Operating Procedures for violence prevention education from Accreditation Canada. It provides a platform for increased awareness of the issue of horizontal violence and bullying in the workplace. Vancouver Coastal Health was able to follow up after a critical incident by using the PVPC to train staff. Lastly, the initiative team was able to be responsive to issues that arose during the pilot, such as commissioning a technical review of the e-learning quizzes or opening up facilitator workshops to other partners. Vancouver Island Health held an additional 7 facilitator workshops using the material developed by the team and have been able to increase the capacity of their health authority to sustain violence prevention education and training.

Summary

The Provincial Violence Prevention Initiative was largely successful in meeting the goals outlined in the charter. The current state assessment and gap analysis was completed; the education modules received a good trial and were very well received. Best practices were shared and a literature review conducted. A violence prevention facilitator program was developed and 114 facilitators trained.

A highlight of the initiative was the very positive feedback about the Provincial Violence Prevention curriculum. The majority of the participants liked the e-learning and completed the modules within expected time frames. However, many employees did not have computer skills and e-learning was not a good option for them. The classroom sessions were appreciated but still pose considerable logistical challenges such as scheduling sessions and arranging facilitators. The facilitator program was also appreciated by those who attended but inexperienced

facilitators need ongoing support and development. A provincial facilitator program requires coordination with continued communication and mentoring plus opportunities for skill maintenance and growth.

Health authorities always struggle with staffing and once a new employee starts work, it is difficult to release them for education and training. A better option would be to have employees come into healthcare already having had violence prevention education. Health authorities could then focus their attention on ensuring employees are provided with adequate orientation and department specific education. Educational facilities that provide healthcare programs are interested in incorporating the PVPC into their programs. This is an opportunity that could increase capacity for healthcare.

The Provincial Violence Prevention curriculum was deliberately developed in a modular fashion to make it very flexible in application. While classroom sessions still have relevance, especially for physical skills, applying learning directly to the care environment may have more relevance and impact. There are many ways the curriculum could be offered in addition to classroom sessions, for example, one module per quarter, one topic in a mini session or safety huddle, personal safety practice sessions, etc. Trained violence prevention facilitators could support violence prevention programs and maintain their skills by facilitating these sessions and/or other activities. This would increase capacity and improve sustainability of violence prevention in healthcare.

BC Healthcare has created a unique violence prevention education and training program. There are opportunities to expand the use of the PVPC to educational institutions, healthcare affiliates, contractors and other jurisdictions. The violence prevention initiative has demonstrated that commitment and support of violence prevention programs including the PVPC is valued by employees and does have the potential to help make positive changes in the workplace.

Acknowledgements

The initiative team would like to acknowledge the Provincial Violence Prevention Steering Committee for creating the impetus for the development of the PVPC. We would also like to recognize the curriculum development team, whose hard work over several years resulted in a curriculum that is now an industry recognized practice for healthcare and a testament to their dedication and perseverance.

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Learning objectives

A standard approach to violence prevention education can positively affect healthcare workplaces. The BC provincial violence prevention curriculum is a unique approach, violence prevention education developed by healthcare workers for healthcare workers. To ensure this program is sustainable and cost effective, a key component is to determine the financial and human resources necessary to support it. This curriculum is effective, engaging and relevant and a key to standard practices in violence prevention in BC.

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Confidence, compassion and exposure to aggression related to stress symptoms among psychiatric inpatient staff

Poster

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Focus: Research

Abstract

Purpose

The purpose of this study is to determine the relationships between the following factors and the experience of posttraumatic stress in a group of psychiatric inpatient direct care staff members. Aside from demographic data, the factors include: 1) past exposure to patient aggression; 2) confidence in managing patient aggression; 3) past exposure to trauma; and 4) compassion fatigue.

Design

A cross-sectional survey will be conducted to collect data, using a questionnaire, at a suburban psychiatric hospital treating acute inpatient adolescents, adults, geriatrics and substance abusers. A convenience sample of 100 subjects is being sought. They will include nurses, psychiatric techs, counsellors, social workers and physicians. The proposal has been approved by the sponsoring institutions I.R.B. and data is projected to be collected between May, 2012 and August, 2012.

Methods

Standardized published survey tools in addition to a researcher-designed demographic questionnaire will be used. Data will be analyzed using descriptive statistics, ANOVA, Pearson's correlation, and Multiple Linear Regression Analyses.

Findings: Data will be analyzed in September, 2012.

Conclusion

It is anticipated that the findings of the study will contribute information related to the relationship between trauma related to patients verbal and physical aggression, and posttraumatic stress symptoms in a sample of inpatient psychiatric staff. In addition, it is anticipated that the findings will indicate the protective value of confidence in managing aggression.

Clinical contribution

This study may provide insight into the potential effect of competence training as a means to increase confidence in managing aggression and consequently decrease the posttraumatic stress effects of patient violence in the psychiatric workplace.

Learning objectives

1. To recognize the prevalence of post-traumatic stress in a sample of psychiatric inpatient staff.
2. To identify factors associated with resilience to workplace stress associated with aggressive patients.

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The Counterpoint Project – Elder Abuse and Neglect: Resources to enhance practice

Workshop

Krista James
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Focus: Education and Training

Abstract

Like many professionals who work with an older clientele, health care practitioners appreciate that elder abuse is a growing phenomenon: at least 4-10% of older people will experience abuse. Nurses, doctors and other staff and professionals are uniquely positioned to detect circumstances of abuse and neglect or identify older people at risk, by virtue of opportunities to interact with older people in their homes, communicate with their other formal and informal caregivers, and make observations about health and well-being. By virtue of a mandate to deliver care and services, the health sector is also well situated to develop relationships of support that could mitigate against increased vulnerability and further abuse or neglect.

However, in practice, addressing elder abuse and neglect raises difficult questions and poses ethical dilemmas. For example,
- What is my obligation to respond to abuse and neglect?
- Does my duty apply to risk of abuse?
- What if the older person may lack mental capacity?
- What laws apply to personal and health information in circumstances of abuse and neglect?
- How can I respond to concerns regarding risk in a manner that respects an older adults right to privacy and independence, and decision to live at risk?

The purpose of the Counterpoint Project is to help health care and social service providers negotiate the various legal and ethical challenges in elder abuse prevention and response. The resources produced as part of the Counterpoint Project include a plain language discussion paper, factsheets for a continuum of health care providers, guidelines for developing policy and practices, brochures and videos.

The Canadian Centre for Elder Law (CCEL) is a national non-profit organization focused on law and aging issues. The CCEL is a national leader in research and tool development on legal issues in relation to elder abuse and neglect. This project was funded by the Division of Aging and Seniors, Public Health Agency of Canada, under the Federal Elder Abuse Initiative.

The Counterpoint tools were developed out of a review of criminal court cases from across the country that dealt with abuse and neglect of older people and illustrated opportunities for intervention by health care and social service practitioners. The Counterpoint Tools are available for free from the CCEL and are a series of excellent plain language resources that can be used to enhance the capacity of practitioners to respond promptly to concerns about abuse and neglect and help insulate institutions from risk. To download the tools go to: http://www.bcli.org/ccel/projects/counterpoint-project.

In this interactive workshop participants will be introduced to the array of tools. Participants will explore how to use the tools in practice and provide input on how to improve and expand the set of tools in order to be more responsive to the practical concerns of health care practitioners. The presenter will follow a story-telling approach that includes scenarios to illustrate abuse dynamics and highlight legal issues in context, and offer participants the opportunity to add stories pulled from the own lives and professional practice in order to better explore how elder abuse and neglect impacts on the practice of all of us.

Learning objectives

Responding to elder abuse and neglect in practice raises complex legal and questions. This presentation will
1. enhance the capacity of participants to recognize abuse and neglect when they see it, and
2. provide participants with basic legal information and tools that will enhance their capacity to respond appropriately and promptly to concerns, in a manner consistent with the legislation governing their province or territory.

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Teaching nursing students about the appropriate use of social media to avoid cyberbullying

Poster

Barbara Jamieson, Sheila Profit, Helen Fraser
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Focus: Education and Training

Abstract

Lateral violence is not new to nursing as it has been cited in the literature for over 20 years. The negative consequences of lateral violence include personal problems, such as low self esteem and depression and organizational issues such as hostile work environments, inability to recruit and retain staff and negative patient outcomes. Lateral violence can be verbal, physical, sexual or psychological.

In recent years electronic communication has been increasingly used by nurses in the healthcare setting and poses another means for lateral violence (cyberbullying).There are many advantages to the use of technology in healthcare from the rapid retrieval of information at the bedside to the rapid exchange of information among health care professionals. Technology can and has been used successfully in the education of health care students and staff, however it must be used appropriately. Nurses and nursing students are increasingly using social media sites like Facebook and Twitter and it is important for them to understand the social media risks.

Our research team was approached by the student services department to determine if cyberbullying was an issue within the university community and if so what could they do to help deal with the issue. A literature review was carried out, ethics approval was obtained and focus group interviews were held with first year nursing students to determine their use of social media, their awareness of cyberbullying and their awareness of appropriate and inappropriate use of social media.

Further focus groups focused on interventions that could be used to deal with cyberbullying on campus. The research will continue in the coming fall as we meet again with students to operationalize a strategy to deal with the issue.

Learning objectives

1. To explain the process we are using to assist nursing students to proactively deal with cyberbullying.
2. To outline the results of our focus group sessions held with students.

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Values conflict, moral distress and insight in the healthcare setting: Staving off potential violence through insight into causes of moral distress

Poster

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Focus: Research

Abstract

Violence in the health sector ranges from extreme, overt violence to passive aggressive violence that manifests in subtle forms of aggression. Much of what causes violence in the healthcare setting has to do with values conflict. This is particularly true in relation to less overt forms of violence. For example, health care workers in hospitals and clinics experience various levels of moral distress brought on by situations where two or more conflicting values are operative. Rather than understanding conflict as caused by differing values, healthcare workers feel threatened and react with more or less subtle aggression toward those holding different values. At times, one or more of the values in conflict can be those of the organization itself. Very often healthcare workers do not have recourse to the *"organization"* to work through the conflict. This can lead to conflict manifesting in interaction among healthcare workers or with clients and patients. The presentation draws on three years of research in different healthcare institutions in Canada. The research sought to study the values operative in healthcare workers (clinicians, nurses, administrators, staff and clinical ethicists) in order to understand their impact on efforts to provide optimal healthcare. A key challenge in this context is values conflict among stakeholders. The goal of the research was to identify areas of values conflict in the healthcare setting, enhance stakeholders' understanding of values conflict and to develop strategies to manage values conflict.

Two tools were used to collect data for the research study:
1) Survey: made available online and in hard copies for everyone working in the healthcare centres.
2) Focus Group Discussions: 30-60 minute focused discussions building on survey questions around values integration and conflict.

Three hypothoses of the study were the following:
1) that values conflict promotes moral distress among healthcare workers, patients and families
2) a key cause of values conflict and hence moral distress comes from healthcare workers' decisions and actions not corresponding to their values or to what they know is the 'right thing to do'
3) guiding healthcare workers through the process of identifying their values and understanding impediments to following their values will reduce their moral distress and address one part of the problem of violence in the health sector.

Values Rounds
Through an analysis of the data collected, several themes emerged identifying both positive and negative experiences of healthcare workers. The themes constituted the basis of a series of education sessions titled *"Values Rounds"* that the research team offered the healthcare centres in order to address the values conflict and moral distress experienced by healthcare workers.

In the context of this research study, our presentation will constitute three parts:
Part I: Members of our research team will present the results of the research study.
Part II: We will present the education package titled *"Values Rounds"* that resulted from what we learned from our research.
Part III: We will present the preliminary findings of the efficacy of the Values Rounds in alleviating moral distress and offsetting potential violence in the healthcare setting.

Learning objectives
1. To demonstrate that values conflict minimizes moral distress and staves off violence in the healthcare context.
2. To demonstrate that values conflict deescalates the experience of threat and promotes willingness to enter into dialogue and work through conflict.

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Aggression, the weapon; Situation, the trigger: An immersion workshop on verbal strategy decision making

Workshop

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Focus: Education and Training
Keywords: Nursing education, verbal aggression, linguistic science, situation awareness/processing science

Introduction

This workshop represents the conceptual framework of a government-funded research project which is currently in progress. The grant goal is the formulation of a nursing communication education approach which can effectively address current dehumanizing trends in educational and clinical interactions.

As the 2010 Conference on Violence in the Health Care Sector highlighted, Health Care communication patterns have shown signs of stress in many parts of the world. Reports have demonstrated that both professional and lay care providers around the world are struggling with the communicative challenge of building mutual understanding, respect, trust, and collaboration between providers and between providers their clients. This interpersonal orientation and communication skill can become overwhelmed at any moment if an unsuspected emotional trigger sets in motion the deterioration from cooperative to aggressive communication.

Some studies have suggested that time allocations for health care communication training has come under great pressure from the demands of technological and therapeutic developments. Thus, any promotion of greater attention to communication mastery must be broadly evidence based, fearlessly innovative, and highly intuitive to both faculties and students. Such approaches would be significantly strengthened if informed by not only health care science but also by the best of the social sciences as well as modern high-risk environment science.

Theoretical Considerations

The endeavor of this workshop is to apply interdisciplinary science to one factor of health care communicative competence. This factor, conversation situation awareness, profoundly impacts participant speech strategy and tactic decisions. Such decisions fall within the realms of linguistic sub-disciplines such as anthropological, sociological, and computational linguistics, as well as the formal sub-discipline known as pragmatics, which will serve as the primary linguistic perspective for the workshop. Pragmatics concerns itself with how speakers go about arriving at mutually understandable, socially useful meanings within specific situations. For example, what situational factors would a speaker use to construct socially useful interpretations in the following two situations?

(a) Encountering one's supervisor in a corridor draws the utterance, *"What's up, Katz?"*
(b) Encountering the same supervisor in her/his office, after being summoned there, draws the utterance, *"What's up, Katz?"*

Interpretation of the senses and functions of the utterance in (a) and (b) relies heavily not only upon conversation factors but also upon factors that may have lead up to it and those that surround the conversation as it evolves. Primary vs. extended senses are differentiated by their associated referents, speaker social roles, and setting components. Disambiguating an utterance meaning involves the interplay of community communication norms as well as its norms for interpreting communication acts. Thus, when conversation participants represent broadly different speech and life style communities, this critical process can be profoundly compromised, leading to pragmatic failure.

The workshop task, however, is to tackle communication at the far edges of human compatibility. Therefore, violation of human worth via perceived and/or intended aggressive communication will also be approached in line with the growing understanding that health care settings share important similarities with other high risk professional sectors. Thus, additional complementary insights from aviation and military Situation Awareness science will be embedded within sensory, interpersonal, discussion, and problem solving experiences. Participants in the workshop will be presented with a variety of safe, yet somewhat non-normative situational factors for interaction, contemplation, and discussion. Discussions will revolve around their normative situational expectations, emotional responses, chosen reactive strategies, and their analyses of their cognitive processes.

Some computational linguists in the late nineteen eighties suggested that the most revealing indicator of an individual's global (intellectual/emotional) intelligence might best be found in the ability to successfully navigate an unbounded, spontaneous conversation with another human being. This assessment grew out of a growing awareness among artificial intelligence researchers that this human phenomenon is actually far more demanding of the human mind than had previously been supposed.

The predominating difficulty uncovered was the massive processing task involved in even the simplest natural conversation. Within milliseconds, the conversation participant processes filtered memories of past events along with predictions for a broad range of possible interaction outcomes. Virtually simultaneously, the same individual is processing input from all of their senses about all of the detectable components of the speech situation. Now add the process of producing meaningful sounds, decipherable grammatical and lexical selections, normative pragmatic (*"appropriateness"*) choices, and the comprehension of language input that is unique in that it is being heard for the first time ever in the current situation and may also be unique to the listener in its content, form, and delivery.

Such a massive processing task demands maximum economy of mental resources. This is accomplished via streamlining of both input and output. Perhaps the clearest illustration of this was presented by a rural craftsman of hand-made hunting decoy ducks. An interviewer asked the craftsman how he could produce such life-like ducks. *"Well,"* taught the elderly gentleman, *"I simply think of a duck and cut away anything that doesn't look it."* Experimentally, aeronautical pilot training research has suggested that the most effective way to train pilots is via a systematic interaction with a broad range of scenarios which become retrieved when needed. Rather than processing all the bits and pieces, the pilot, in a sense, shops for a packet with the seemingly best fit for the current packet of data.

One potential cost of this streamlining is the possibly premature glossing over of available input data and/or possible action options. Essentially, one byproduct of sufficiently focusing on a given task appears to be a decreased awareness of and thus, decreased utilization of other situation factors. Task failure, therefore, may be as much or more a result of failure to account for and prioritize non-task factors as it is a failure of insufficient task knowledge or skills.

This would be no less true of a clinical conversation than of a physical task taking place in a jet cockpit, building fire scene, police-arrest scene. Every health care task moment is, of course, clothed in the grand task of creating the highest level of support for human wellness. Thus, situation awareness failure at a particular task, including conversation, would compromise this goal and possibly place the client and/or the provider at risk of serious harm.

Workshop Overview

As applied to clinical communication, the empoyed hypothesis of this workshop is that *"glossed-over"* factors present one of the greatest areas of risk for errant transitions from cooperative to aggressive interaction. Rationale for this hypothesis will be presented as a foundation for the below immersion experiences that will follow.

First, a variety of relatively minor, yet rather non-normative situational factors will be arranged for interaction, contemplation, and discussion. Discussions will revolve around the participants' normative situational expectations, emotional responses, chosen reactive strategies, and the participants' analyses of their situation processing styles.

Secondly, the participants will be presented with a selection of failed communication scenarios, asked to make judgments about their appropriateness, to indicate the specific situation factors that lead to the judgments, and then to restructure each scenario so as to modify its nature in specific ways.

Finally, in additions to their own styles, the participants will assess what they perceive to be the predominating or most influential styles at their places of work, and then to propose individual and institutional processing style modifications that might be beneficial and to brainstorm promising approaches to affect this remodeling process.

The below propositions will be demonstrated and collectively explored and applied to clinical settings.

1. The potentials for aggression (1), verbalization (2), and sensory input processing (3) are, in the absence of significant neuropsychological dysfunction, resident within all humans.
2. Given similar levels of sensory function individuals within a given situation will process similar sets of environmental sensory input although from subtly to significantly different physical vantage points.
3. Other than individuals suffering at the extremes of neuropsychological dysfunction, humans neither vocalize nor exhibit verbal aggression at all times nor under all types of situations.
4. An individual transitioning from one situation another will do so with a unique set of psychological triggers: The below table represents one possible representation of such Trigger Sets.

Situation Transition Triggers				
Sustainers		Needs Beliefs Risks		Enticements
Present in Situation 1	→	Transition*	→	Present in Situation 2
Detractors		Memories Emotions Strategies		Deterrents kec

**This does not imply a strict separation of situations but rather a mental processing of dynamic shifts in situation components.*
3a. This Trigger Set provides an internalized, easily-interpreted system for monitoring and assessing subtle changes in one's evolving surroundings.
3b. The Trigger Set is unique to every individual. While different sets will exhibit areas of overlap, the likelihood of complete overlap is virtually impossible.

5. Therefore, the development of an individual's *"situation trigger profile"* may enhance the value of *"histories of violence"* in that such a profile would explore emotions that facilitate as well as hinder collaboration.
   5a. There would be a coordinated effort to amass sufficient data to compile a useful profile of a care client's personally significant life settings and living patterns.
   5b. This would be enhanced by the addition of professional anthropologist trained in the development of sound ethnographic profiles and their interpretations.
   5c. Such an investigation would be coupled with an assessment of the degree to which the current situation reproduces specific overlapping elements, especially those which appear likely to overlap with past triggering situation components.
   5d. Application of the above profile process to health care providers would greatly enhance the power of the client's profile to create a client-specific scenario with optimum supportive potential.
   5e. The addition of *"high risk"* setting sciences would further strengthen this model and render it more effective to emergency situations lacking sufficient time for profile development.
6. Productive assessments rely heavily upon an institution-wide awareness of typically under-considered background, as well as, highly-prioritized foreground setting and interpersonal factors.

References

Complete references and multidisciplinary reading lists will be provided to all workshop attendees and to registered conference attendees upon request.

Learning objectives

1. The expression of aggressive behavior is tightly linked to specific situational triggers.
2. These triggers may quite commonly be the very situational factors that are streamlined out of the mental SP rubric for the sake of time and mental energy.
3. Therefore, a trained-in sensitivity to situation factors often filtered out may enable the care professional to detect the unexpected trigger before it sets off the behavior.
4. Perhaps most importantly, such sensitivity may guard the care professional from becoming that very trigger.

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Strategies for the mitigation of workplace violence in a Jamaican hospital

Paper

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Focus: Research
Keywords: Workplace, violence, mitigation, Jamaica, health workers

Abstract

Objectives

To determine strategies to mitigate workplace violence in a Jamaican hospital through collaboration with hospital employees.

Methods

Two focus groups of 22 members of staff representing eight disciplines. One group consisted of eight females employees while the other had eight females and six males. Each participant had been at the institution for more than five years. The discussions were facilitated by the same moderator and a semi-structured guide was used to stimulate sharing of experiences with violence at work.

Results

All staff had experienced workplace violence, with A&E and security staff at greater risk for physical violence. Nurses were more likely to experience verbal than physical abuse. Patients were more likely to exhibit violent behaviors following long waiting periods. A lack of understanding of medical jargon, the triage system utilized in A&E, and the necessity to refer clients to Primary Health Care facilities sometimes resulted in violent behaviour. Underreporting of violent incidents was common as invariably no action was taken. Strategies to mitigate violence included improved customer service, employment of additional staff to adequately deliver services, implementation of workplace violence policies and educating the public on proper use of the healthcare system, thereby reducing overcrowding in A&E.

Conclusion

There is a need to raise the level of awareness regarding workplace violence among health sector workers in a Jamaican hospital. Additionally, workplace violence can be mitigated through education and by the implementation of multiple strategies using a collaborative approach among employees, health sector administrators and policy makers.

Background

Violence in the work place is a serious health and safety issue and is the fourth leading cause of fatal occupational injury in the US (US Department of Labor, 2000). Approximately 40% of healthcare workers worldwide are exposed to violence, including physical assault and verbal threats, while on the job (Ayranci et al., 2006). This occupational hazard is ill-defined and underreported with varying definitions across international agencies.

At two hospitals in Kingston Jamaica, 71% of the nurses and doctors interviewed reported encountering violent or threatening patients or family members at least once in the last year (Lindo et al., 2006). In addition, 70% of Accident and Emergency professionals encountered violent or threatening patients or family members at least once per month. Staff members working with psychiatric patients faced a higher risk of physical assaults compared to other healthcare staff. Nurses were most likely among health professionals to be verbally abused in Jamaica (Jackson & Ashley, 2005).

In 2010 healthcare workers at the Kingston Public Hospital (KPH) were exposed to lethal violence from gunfire and large intimidating crowds on the grounds of the hospital associated with events in the inner-city communities surrounding the hospital. This has led to the Director of Nursing's call for improved security for hospitals and for strategies to assist staff in combating workplace violence (WPV). It reflected the profound way in which the epidemic of violence has impacted the healthcare workplace and its urgency worldwide (Ayranci et al., 2006).

Workplace violence includes physical, mental and psychological insults; however, the extent to which KPH workers are aware of this range and the extent to which current reporting system captures all insults are unknown (Wasell, 2009). Strategies to combat WPV in the hospital require that all staff are fully aware of what constitutes WPV to guide the development of effective intervention strategies.

The study aimed to determine strategies to mitigate WPV in a Jamaican hospital through collaboration with hospital employees. The objectives of this study were to;
1. Explore the experience of staff with workplace violence the KPH,
2. Raise the level of awareness regarding workplace violence at the institution,
3. Determine strategies to mitigate workplace violence at the Kingston Public Hospital.

Methods

Study design
Two focus groups discussions and four workshops were conducted at the institution

Population and sample size determination
KPH is a 500-bed tertiary care, major trauma hospital located in close proximity to communities with high levels of violence and gang warfare. The hospital has a police post adjacent to the accident and emergency department

A purposive sampling technique was used to facilitate two focus group discussions which included 22 members of staff from pharmacy, Accident and Emergency, medical surgical wards. Participants were employed as doctors, nurses, ward assistants, porters, security guards, pharmacist and customer service representatives. The focus group discussions were facilitated by the same moderator using a semi structured guide to stimulate sharing of participants' perspectives. Audiotapes of the discussions were transcribed and scripts manually analyzed thematically. The findings of the focus group discussions were shared with employees from the units studied and were attended by more than 100 employees. Participants were provided with literature on WPV developed by the University of Maryland.

Results

Eight disciplines were represented by the groups and one group consisted of eight female employees while the other had eight females and six males and all were employed at the institution for more than five years.

Workplace violence was commonly experienced
Participants in both groups were of the view that the issue of workplace violence was a real challenge, especially verbal abuse. Almost all the participants reported WPV was a daily occurrence; however, physical violence by patients/ relative was mainly directed at categories of staff such as security officers and personnel in the A&E department. Nurses were more likely to experience verbal than physical abuse. These quotes reflect some of the sentiments expressed:
"Most times I wish I didn't have to come here." "Some patients have no manners or respect for us". "I see a patient 'box' (hit in face) a doctor because his relative died". "Some patients come with the mindset that they have to behave like bad-man to get through"
Lateral violence between the enrolled assistant nurses and the registered nurses was also reported.

Participants coped with their exposure to violence by ignoring it stating; *"I just make it roll off my back," "you learn to deal with it"*. They claimed; *"when you report nothing happens"* and complained that *"Patients are not always right"*. The nurses studied were aware of reporting polices for incidents involving WPV; however, this was not common to all categories of workers. One nurse stated "Management needs to see how best to manage complaints because sometimes patients abuse the staff and management takes side with patients.

The doctors in the group reported knowledge of sexual harassment and threats by family members among their colleagues.

Further, the location of the hospital in a volatile community led a security guard to express *"A police station is needed here… police post can't do follow-up investigation and the staff turnover is high"*, *"When we have to walk to the Police station it too dangerous."* Under reporting of violent incidents at the institution was pervasive and the absence of a comprehensive WPV policy was highlighted by the participants.

Triggers to WPV
The focus group participants were of the view that patients were more likely to exhibit violent behaviours following long waiting periods, anger due to death of relatives and a lack of understanding of medical jargon. The triage system utilized in A&E sometimes necessitated the staff to refer clients to Primary Health Care facilities and a lack of understanding of this process was reported as a trigger to WPV. The participants' views were typified by the following quotes. *"In the registration area the port holes are too high and in order for the patient to hear well sometimes you have to speak loud and the patient think you shouting at them and start getting angry"*.

Strategies to address WPV
The employees felt WPV could be mitigated by the adoption of a clear, equitable policy for the investigation of WPV complaints at the institution. Participants suggested public education could assist in the mitigation of WPV with an emphasis on valuing the staff, institution and explaining how the system operates: *"They all think they must get through before everyone else even when they come last"*.

Improved customer service, increased staff complement and other resources to expedite services could also be implemented to address WPV. One porter recalled, *"Some staff don't talk to the patients good"* and an employee of the pharmacy suggested; *"We need to have ongoing training in customer service for all staff"*. Structural changes such as the installation of panic buttons and modification of triage room doors were also recommended by the study participants. It was suggested the provision of educational videos for key areas where people had to wait for long hours may assist in reducing WPV.

Workshop report

The findings of the focus group were summarized and shared during four workshops conducted over a two day period which facilitated more than 100 employees. The employees welcomed the workshop and saw it as an important avenue to contribute to the issue of WPV prevention. They confirmed the findings of the focus group discussions and also added that Radiology was an area of threat for staff because patients often spend time alone with the radiologists in an isolated area thereby placing them at risk for WPV. An employee recalled an incident where a police officer was disarmed in the radiology unit while guarding a client. The workshop participants also identified the need for support for WPV prevention from the hospital's management and the Ministry of Health. They suggested that a clear message be sent to the administrators endorsing zero tolerance to WPV and indicated their readiness for change. It was argued that increasing the safety and security of employees would yield improved customer service.

A&E staff reported interventions which they adopted such as the avoidance of the use of triage rooms which were considered unsafe (no windows or a single exit). There was great apprehension among staff walking in public spaces and being accosted by KPH clients as this could positive or negative depending on the clients' experience.

Suggestions for reduction in WPV

- Additional customer service training for all staff
- Panic buttons be installed in critical areas where health workers interface with clients on a one to one basis and in an enclosed/ confined spaces including :
  - Radiology (x-ray rooms)
  - A&E (triage rooms)
- Security guards be specially trained and provided with appropriate response protocol. Currently, on many occasions the security guards appear hesitant to remove violent and threatening persons due to fear of reprisals.
- Implementation of protocols to control access of visitors.
- Inviting the police to work as a member of the WPV Health Sector Environmental Health and Safety Committee, KPH to improve security
  - Persons expressed fear in accompanying police to nearest police station
  - Dissatisfaction with level of support from police
  - Police station requested rather than police post
  - Limited data collected at police post regarding workplace violence
- Improved lighting in staff car parks, since persons felt threatened

Discussion

WPV presented a clear and present danger to healthcare workers at the KPH. The level of threat was heightened because of the hospital's close proximity to inner city communities which experienced frequent outbreaks of violence. In addition, WPV involving clients and staff of the hospital was attributed to the large number of clients using the hospital and lengthy waiting periods for service. While this may have been exacerbated by the recent abolition of user fees by the Ministry of Health and an increase in the number of clients, this situation was observed previously (Jackson& Ashley, 2005).

Focus group discussions and the workshop regarding WPV and its mitigation yielded great interest and participation among the staff. The workshop identified Radiology as a high risk area for violence where health workers and clients are often in an enclosed room. Although this area was not identified in the focus group discussion, Radiology has been seen as a neglected area where WPV is often perpetrated. In one Italian study 6.8% of radiologists experienced physical violence over a one year study period while 5.5% reported abuse at the time of the study (Magnavita et al., 2011). Further, 65.2% of radiologists reported that non-physical violence affected them throughout their working lives (Magnavita et al., 2011). The group verbalized, that there was an urgent need to implement strategies to mitigate WPV among health workers at the KPH. These strategies include improved customer service, infrastructural changes and training of security personnel to effect an appropriate response. Communication between emergency department workers and security personnel is key to effective response to violent and threatening incidents (Gillespie et al., 2012).

Further, there was consensus regarding the need for a specific WPV prevention policy in the heath sector, generally. They identified the need for full support of the Ministry of Health and the management of the hospital. This augured well for the drafting WPV prevention policy and the implementation of control measures to mitigate WPV (Harding 2012). There is a need to educate health workers on what constitutes WPV and a sustained campaign to mitigate WPV including the adoption of a zero tolerance approach (Gillespie et al., 2012; Harding 2012; Kowalenko et al., 2012; NIOSH, 2006; Wassell, 2008).

It appeared that WPV at the KPH could be mitigated by implementation of several institutional strategies based on a collaborative approach among employees and health sector administrators and policy makers. However, there is a need for capacity building in knowledge of WPV and advocacy for policymaker and management commitment.

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Learning objectives

1. There is a need for a workplace violence prevention policy for Jamaican hospitals.
2. Health workers can make significant contributions to the mitigation of workplace violence.

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Managing dementia-related aggression in long term care using an activity-based educational approach

Paper

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Focus: Research
Keywords: Older adults, dementia, responsive behaviors, person-centred care, workplace safety culture, educational development

Introduction

Aggressive behaviours, frequently manifested as a result of cognitive impairment, are common in long-term care (LTC) settings (Dupuis & Luh, 2005). These aggressive behaviours can include kicking, biting, hitting, pinching and scratching (Cohen-Mansfield, 2008). Studies report that physically aggressive behaviours occur in 10% – 50% of persons with cognitive impairments in Long-Term Care (LTC) homes, contribute to workplace distress and require educational interventions to equip staff with the skills necessary to respond effectively (Buhr & White, 2006; Tannazzo, Breurer, Williams & Andreoli, 2008; Zeller, Hahn, Needham, Kok, Dassen & Halfens, 2009). It is identified that aggressive/responsive behaviour in LTC occurs on a continuum of intensity, severity and risk that can escalate to injury and harm to residents and staff (Cohen-Mansfield & Taylor, 1998). All staff in LTC units must therefore be able to support residents who are displaying physical aggression using respectful and person-centred techniques that can be used to momentarily redirect the resident with dementia away from an altercation with a co-resident or staff member. This skill is needed for all team members including nutritional aides, personal support workers (PSWs), registered staff such as RNs and RPNs, and housekeeping staff and maintenance staff. Unfortunately, most are not trained in response techniques that could be a significant contribution to overall team functioning and workplace health (Dupuis, Wiersma & Loiselle, 2004).

Background to Gentle Persuasive Approaches (GPA) Curriculum

The Gentle Persuasive Approaches (GPA) curriculum is grounded in the research-based philosophical principles of person-centered care (Kitwood, 1997) and the need-driven, dementia-compromised behavior (NDB) model (Kolanowski, 1999; Richards, Lambert & Beck, 2000). Key curricular points provide care givers with an opportunity to participate in a dialogue wherein they uncover significant life events and preferences that give meaning to the lives of the older adults in their care. In addition, dementia behaviours that participants might traditionally view as *"disruptive"* are understood to be the result of unmet individual physical, psychological, social, spiritual and/or cultural needs. In particular, behaviors typically labeled as *"aggressive"* are reframed so care givers interpret them as an attempt to re-exert control over a life that has become unfamiliar and frightening (Talerico & Evans, 2000). Overall, the primary framework of the GPA curriculum is the view of the older adult with dementia as a unique individual who is striving to relate in the world in an attempt to make needs known, and thus, the corresponding behaviors should be examined for themes that help to identify those unmet needs. Interventions should then be tailored to meet those needs identified. The GPA program is formatted in four distinct modules designed to cover several main objectives: Module 1. Understand that the person with dementia is a unique human being who has an emotional response to stimuli; Module 2. Explain the relationship between the dementia process and the resident's behavioural response; Module 3. Describe the emotional, environmental and interpersonal aspects of communicating with persons with dementia during an aggressive episode; Module 4. Choose strategies that serve to diffuse aggressive behaviours rather than escalate them, and 5. Demonstrate the suitable and respectful protective techniques used to respond to the most aggressive/responsive behaviours.

Since its inception in 2005, the GPA program has been delivered to 60,000 clinical and support staff representing over 700 care facilities in the province of Ontario, Canada. Many facilities have trained 100% of their staff, and have requested an ongoing refresher program, as was the case with the LTC facility that was the focus of this study. Although receiving the full 7.5 hour GPA program as a refresher dose is sound pedagogy, requiring staff to participate at this level would be cost prohibitive.

Adult learning theory and staff development literature supports that competencies are strengthened when there is formal opportunity for refreshment of associated knowledge and skills (DeYoung, 2009; Kalisch & Curley, 2008; Vella, 2002). However, sustainability of any education programs related to dementia-related aggression management in LTC homes has received very little attention in the literature. Once large training programs such as GPA have been initiated, there have been few attempts to study the *"reinforcement"* of learning to determine the best approach to ensuring that best practice competencies are sustained over time. Learning theory suggests that repeated *"doses"* or *"inoculations"* of critical material is important for sustainability of new learning and acquired skills (Broussard, McEwen & Wills, 2007). Therefore, the intent of this project was to test the effectiveness of a total refresher dose of 100 minutes using activity-based learning strategies that are cost and time efficient and therefore suitable for implementation to reinforce best practices for the management of dementia-related aggressive/responsive behaviour on an ongoing basis.

Study Objectives

This study aims to determine the effect of being exposed to a 100 minute refresher dose of the Gentle Persuasive Approaches Curriculum (GPA-R) extracted from the full 7.5 hour curriculum (GPA) compared to no refresher exposure (no GPA-R) on the development of responsive behaviour management competency in front-line staff working with dementia residents in LTC using a sequential mixed methods quasi-experimental study design. Bandura's social learning theory (1986) was used as the conceptual framework for this study. The primary research question was: For front-line dementia caregivers in LTC, what is the effect of the GPA-R intervention on capacity to perform skills necessary to manage aggressive behaviours (as measured by self-perceived confidence), when compared to those staff who have had the introductory GPA program but no exposure to GPA-R?

Design

A sequential mixed methods quasi-experimental research design with repeated measures (immediate pre- and post-test and at a 6-week and 3-month follow-up) was used to evaluate the GPA-R intervention in interdisciplinary front-line staff working in a single, LTC facility (Tashakkori & Teddlie, 2003). The staff from two comparatively similar but separate resident care buildings on the same geographical site were assigned to one of two conditions: a) GPA-R refresher program (intervention group), or b) standard educational supports (control group).

Setting

The study was conducted at a LTC home located in a suburban residential community adjacent to a medium-sized metropolitan city in South Central Ontario, Canada. The LTC home is a 378 bed non-profit charitable organization with 550 employees. There are 200 beds comprising of eight resident home areas in the building that received the intervention, and 178 beds comprising of seven resident home areas in the building that served as the control. Each building has its own management and health care personnel. The buildings are separated by large common areas, thus rendering them very distinct from a physical plant perspective. The prevalence of dementia amongst the residents in both buildings is very high, and associated aggressive behaviours occur daily.

Sample

The intervention group comprised of fifty-eight full time and regular part time staff employed in the intervention building. Thirty-five full time and regular part time staff employed in the control building served as the intervention group. Casual staff and those full time staff who have not yet participated in the full GPA program were excluded from the study. The mean age and years of employment experience of staff in both groups was similar. The majority of participants were women. The majority of both groups were PSWs, but included RNs, RPNs, Nutritional Aides, and Housekeepers.

Measures

The main outcome measure was the Self-Perceived Behavioural Management Self-Efficacy Profile (SBMSEP), a tool developed to capture participants' perceived level of confidence related to aggressive/responsive behaviour management. The SMBSEP was developed by the Principal Investigator using Bandura's (1989) principles of self-efficacy. Participants were asked to indicate their perceived confidence in accomplishing the clinical behaviours and tasks necessary to manage responsive behaviours competently. The tool is a 10-item Likert-type scale (Cronbach alpha: 0.93). Staff also participated in pre- and post-intervention focus groups.

Analysis and Results

Data were entered into SPSS statistical software, and analyzed using t-tests to compare change scores between the intervention and control groups. T-tests were run on each of the 10 items of the SMBSEP, as well as comparing total SMBSEP scores (out of 70 possible points) between each of the two groups. Statistically significant results were acquired on all items of the SMBSEP as well as the total SMBSEP scores. Employees who participated in the refresher groups had a stronger sense of confidence in their capacity to manage aggressive behaviors ($p < .001$). In focus groups, participants in the intervention group reported greater success with using person-centered behavioral management techniques when episodes of aggression occurred. Intervention participants reported that the learning activities designed to reacquaint them with key best practices were highly engaging, helped them remember key competencies, and assisted them to discuss potential interventions with workplace peers that strengthened the potential for future collaboration. Thus, front-line caregivers receiving the GPA-R intervention reported greater perceived confidence at the end of the intervention period and these changes were maintained at 3 months post-intervention compared to those staff exposed only to the full GPA program and had not yet participated in the GPA-R program.

Implications for Research and Staff Development

The 100 minute GPA-R program is emerging as a satisfactory approach to refreshing point-of-care staff on key best practices associated with the management of responsive behaviour in LTC settings. Further research can be done to determine how frequently the dose needs to be applied in order to maintain competency. In addition, the

refresher learning activities can be tested in an on-line application for use in rural or underserviced communities in the far northern regions of Ontario, Canada.

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Learning objectives

1. Introducing person-centred behavioural management principles into long term care homes to reduce incidents of aggression.
2. Using the principles of dialogue education to build activity-based learning modules for front-line staff.

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Workplace violence education: Giving staff the tools and the voice

Paper

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Focus: Education and Training

Abstract

In June 2010, all Ontario, Canada workplaces were mandated through a change in the Occupational Health and Safety (OHS) Act (Bill 168) to conduct an organizational risk assessment, to identify workplace safety measures, and to develop and implement a workplace violence policy that clearly defines workplace violence, outlines preventative measures, and describes reporting and debriefing requirements when incidents of workplace violence occur. As well, organizations were required to develop and implement an education program to enable employees to familiarize themselves with the organizations and their own responsibilities in preventing and/or dealing with workplace violence.

In response to this legislation, University Health Network (UHN), a large urban multi-site acute care hospital with over 11,000 employees, developed a series of eLearning modules to support staff in understanding the new requirements for all workplaces and their own responsibilities in ensuring a safer work environment.

UHN has a comprehensive Learning Management System (LMS) that is available 24/7 to all staff through the web using home or work computers. Records of course completion are tracked in the LMS to measure participation in the education program.

Clinical and administrative leaders from nursing and mental health, along with OHS staff, security services, and the diversity department developed the content for 4 workplace violence modules. eLearning instructional designers then worked with the content to build the modules and upload to the LMS. These modules include: 1) An Overview of Workplace Violence Policy; 2) Response to Workplace Violence; 3) Response to Domestic Violence Occurring in the Workplace; and, 4) Workplace Harassment.

Module development was based on hospital policy, provincial legislation, current literature and provincial/hospital data as well as hospital based scenarios and responses. The objectives of the modules are to educate staff regarding the unacceptable nature of workplace violence, the hospital commitment to safety, and to reinforce internal processes and structures to prevent or address violence. Key topics include staff education about understanding the cycle of violence and de-escalation techniques, recognizing the continuum of violence, personal safety, addressing privacy concerns, describing and reinforcing the hospital response algorithm and outlining reporting processes for both staff and managers.

These interactive modules are based on adult learning principles and, while intentionally designed to be comprehensive, they are short and user friendly so that they can be preferably completed within work time. Completion of the first module was mandatory for all staff as part of Bill 168 requirements as well as in preparation for the hospital accreditation. LMS reports are routinely monitored by OHS staff.

As the hospital employees have increased their knowledge and understanding of Bill 168 there has been increased expectation of staff to have educational materials and support. The eLearning Modules have been an invaluable resource to not only support staff but to provide a clear indication that UHN takes workplace violence and the legislative requirements seriously.

Learning objectives

1. To describe the process of how clinical, adminsitrative and education experts within an acute care hospital partnered to develop a 4 part series of innovative Workpalce Violence ELearning Modules.
2. To review content, design process and implementation of a 4 part series of Workplace Violence ELearning Modules.

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Understanding experiences of client violence: The psychologist's story

Paper

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Focus: Research

Abstract

Research in the UKs National Health Service (NHS) setting found that health care staff were four times more likely to experience work related violence and aggression compared to any other UK workforce (National Audit Office, 2005). As a result of this violence, health care practitioners experience threats to personal and professional identity and report self-blame, guilt, anger, fear and a loss of confidence in their work role (Littlechild, 1995, 2002; Snow, 1994). We were particularly interested in the personal experiences of workplace violence experienced by Counselling and Clinical Psychologists. A recent study examining the extent of violence for trainee practitioners in clinical psychology revealed that 62% of the sample (N=207) had either been verbally assaulted, been exposed to violence in the workplace or had been a victim of violence (Gately and Satbb, 2005).

We were interested in focussing on the ideographic (rather than the nomeothetic) and carried out eight research interviews with practicing Counselling and Clinical psychologists who delivered therapeutic services in the UK NHS. We collected their subjective experiences of violence that they had encountered with clients and analysed the data using Interpretative Phenomenological Analysis (IPA) (Smith, Flowers and Larkin, 2009). We were able to draw out the participants experiences in more detail and explore the phenomenological experience in the context of the individuals personal and professional identity on a one-to-one basis with clients and as a co-worker in a multidisciplinary team setting. Initial findings suggest a number of major themes which include physical and psychological responses to the incident, psychologist as victim, the ruptured client-therapist relationship, empathy towards other health care staff and framing client violent behaviour using psychological knowledge.

Given that not all incidences of violence towards health care professionals are reported and psychological abuse is significantly underreported (Arneetz, 1998; Viitasara, 2000), the paper will further discuss findings as Psychologists regularly find themselves dealing with clients suffering extreme mental distress, chronic mental illness and drug and alcohol abuse. The paper will conclude with a set of recommendations for training Psychologists not only in relation to individual client work but incorporating the Psychologists role as part of the multidisciplinary team membership that delivers a comprehensive service package to individuals and communities. Implications for continuing professional development for qualified Psychologists will also be included.

Learning objectives

1. Understanding subjective experiences of violence as a professional clinician.
2. Recommendations for training counselling and clinical psychologists.

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Improvement course about violence prevention: The impact on health sector professionals

Poster

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Focus: Education and Training

Background and context

The effects on relationships and violent situations are a major impeditive to human development as well as being considered a serious public health problem. In general, the Brazilian academic background has shown to be strictly biomedical, ignoring biopsychosocial factors, not including violence in a multidisciplinary way, going unnoticed by graduation students of the health field.

Methodology

This analytical study and evaluation of knowledge was conducted during two elective courses: 'Prevention and Treatment to People Vulnerable to Violence' in a Public University of the State of So Paulo, Brazil, the first on October-November 2011 and the other one on May 2012. Among the fifty participants there were students from the first, second and third year of the Nursing and Medicine course, the first and third year of Psychology at a private university in So Paulo State, social assistants, psychologists and a biologist who had already completed the graduation . This course took about 30 hours, 22 hours being given to the theory using the strategy of cases discussion and under the eight hours remaining, the students visited the UNIFESP (Federal University of So Paulo) services and some from other institutions who attend victims of violence. The participants answered a questionnaire containing multiple choice questions concerning topics of violence before attending classes, for analyzing the previous knowledge on the subject and the same questionnaire after completing the course to measure the effectiveness of it.

Findings

We noticed the great lack of preparation of current and upcoming healthcare professionals to face the issue, since many times it is not worked at undergraduate level. Before attending the lectures of the course, only 8% of the people analyzed felt prepared to identify and assist violence victims against 74% of the participants at the end of the course. Despite this, it is concluded with this research, that after learning about the theme they became more confident, and were able to absorb the content in a meaningful way, as before the discipline the indice of correct answers was 56.6% and after it became 74.4%. According to the highlighted answers, it is concluded that the universities also have been forming professionals with low sensitive for the topic of violence, which ultimately may exacerbate injuries and consequences for the victims.

Implications

Focusing on a more humanized assistance, there is a great necessity to include prevention and care to the violence victims in a definitive way within the curriculum of healthcare courses. It would be a gain for the public health to have professionals well qualified to perceive the institutional violence or the one experienced by the user and above all to shelter properly these victims.

Learning objectives

1. To demonstrate how the current and upcoming healthcare professionals of Brazil perceive violence and expose the effectiveness of an improvement course on the topic.
2. To affirm the necessity to include this theme into the curriculum of the university.

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Effective reduction of restraint and seclusion in the psychiatric emergency department while maintaining safe milieu

Paper

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Focus: Education and Training
Keywords: Psychiatric emergency, aggressive behaviour, restraint and seclusion

Introduction

In 2008, the Johns Hopkins Hospital (JHH) Department of Psychiatry initiated Crisis Prevention Management (CPM), a provision of care which focused on maintaining safety of psychiatric patients and care staff while using the least restrictive interventions possible in an effort to reduce the use of seclusion and restraint. The JHH Psychiatric Emergency Department (PED) adopted CPM in 2009 in an effort to reduce the use of seclusion and restraint in an acute care setting. When this project started the PED faced many challenges. The treatment area was small and restrictive, and not conducive to comfort or privacy. It was difficult to meet basic needs of patients with regard to rest, nutrition and hygiene. There was a lack of adequate staffing. Patients present in acute psychiatric distress from all major diagnoses, often with medical and substance related co-morbidities Patient presentation and treatment was further complicated by history of violent behavior, involuntary status, non- compliance, poor coping and lack of social supports.

Objective

To examine factors associated with restraint and seclusion use in the psychiatric emergency department and evaluate ability to reduce this use.

Method

Before January 2009, all clinical and non- clinical PED staff were trained in identifying signs of patient's escalating anger and aggression. Registered nursing staff was educated in the use of personal safety plans; early behavioral intervention strategies and helping the patient align PED process and expectations. Hourly assessments of patient status and comfort needs were performed. Staff partnered with patients and advocated to meet their needs for comfort and safety. While the inpatient units also implemented a variety of comfort and distraction measures, these were not used in the PED due to the lack of space and privacy needed. Data collected from 2007- 2008 was used as pre- intervention and 2009-2011 post- intervention. Data was collected on a standardized aggressive patient management tool and seclusion and restraint flow sheet which recorded precipitant to incident, other interventions tried, description of incident, type of restraint/seclusion, staff involved, medications given, post- incident patient behavior with real-time assessments every 15minutes to hourly, interventions offered during restraint/seclusion, and staff, staff and patient debriefing.

Results

Total use of restraint and seclusion in 2007 = 392 hours. Total use of restraint and seclusion in 2011 = 122 hours. Total annual patient volume has remained between 2600- 2700. No significant change in patient demographics has been observed. The reduction in seclusion and restraint shown is based solely on assessment and communication interventions.

Conclusion

Our results suggest that the use of restraint and seclusion in the acute care setting can be reduced, patient care and satisfaction improved and a safe milieu maintained with effective implementation of alternative strategies.

Learning objectives

1. Discuss complications of restraint and seclusion and the systematic change in the use of as a standard practice and therapeutic process.
2. Describe core strategies utilized to promote change in safe care delivery.
3. Identify challenges to reducing restraint and seclusion in the acute care setting.

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Gender difference in psychiatric inpatient violence: A perspective from India

Poster

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Focus: Practice

Abstract

Background and context

Since violence among psychiatric inpatients is a grave concern in mental health, various possible predictors have been examined with inconclusive results. The study aims to examine gender differences in the nature of violence committed by adult psychiatric inpatients. The study was conducted in the adult psychiatric wards of National Institute of Mental Health and Neurosciences (NIMHANS), a state-run tertiary care psychiatric teaching hospital located in the city of Bangalore in South India. Hospital policy mandates that a same gender family member usually accompanies the patient as a caregiver during the hospitalization except in admission in a closed ward.

Methodology

One hundred consecutive incidents involving male and female inpatients exhibiting violent behavior in the hospital were included. Within 24 hours staff nurse on duty was interviewed regarding the incident. Incidents were assessed using Staff Observation Aggression Rating Scale- Revised (SOAS-R) and Quantification of Violence Scale (QOVS).

Findings

Study sample comprised of 66 males and 34 females with significantly higher comorbid substance use amongst males (36 %). 15 % of females were violent towards staff nurses; none among males. In both groups, majority of incidents were provoked in nature with the most common cause being denial of a patients demand and most common target being the accompanying family member (70%). There was no significant difference in mean SOAS-R and QOVS scale scores.

Implications

The higher incidence of violence towards staff by females could be because there may be a tendency by the staff to ignore signs of violence from females due to a preconceived notion of females not being violent while any similar behavior from males on the other hand, may have been managed more aggressively. Any patient, irrespective of gender could pose a potential risk for inpatient violence and hence, a well coordinated management plan can prevent or decrease violence severity. The risk for violence posed by any patient should not be assessed on the common perception of gender roles and identity in such a setting. This requires to be highlighted as a part of training programs for the staff nurses and in the formulation of guidelines for managing inpatients in the psychiatric wards. The study revealed no differences between the two genders in nature, severity and consequences of violence. The setting and admission policies of the hospital mandating one family member to accom pany the patient through out the inpatient stay might have a bearing on the finding that family members were the commonest target regardless of gender. In India, families assume the role of the principal caregivers because of a longstanding tradition of mutual interdependence within family relationships. In a country with limited number of mental health professionals, such a system of using a family member supplements the care by trained staff.

Learning objectives

1. Any patient irrespective of the gender can be a perpetrator of violence in the psychiatric inpatient setting.
2. The risk for violence posed by any patient should not be assessed on the common perception of gender roles and identity in a psychiatric inpatient setting. This requires to be highlighted as a part of training programs for the staff nurses and in the formulation of guidelines for managing inpatients in the psychiatric wards.

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On-line workplace violence prevention training for nurses

Poster

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Focus: Education and Training

Abstract

Background

Healthcare workers are nearly five times more likely to be victims of violence than workers in all industries combined. While healthcare workers are not at particularly high risk for job-related homicide, nearly 60% of all nonfatal assaults occurring in private industry are experienced in healthcare.

Methodology

The National Institute for Occupational Safety and Health (NIOSH) partnered with Vida Health Communications, Inc. (Vida) and experts in the field of healthcare violence prevention to develop an on-line workplace violence prevention best practices program for nurses. This program provides prevention basics, raises awareness of workplace violence, and describes response techniques to decrease the number of injuries and illnesses due to workplace violence. Interactive content such as video vignettes, video interviews and review questions are utilized throughout the program. Five case studies based on real-life incidents are presented with notations to highlight key points that reflect back on the course content. Topics covered by the case studies include: 1. An intervention with an agitated psychiatric patient; 2. Aggression by a patients family member; 3. A home care setting where a patient threatens homicide of the healthcare provider; 4. Responding to injury from a cognitively-impaired patient; and 5. Dealing with patient anger and inappropriate sexual behavior.

Findings

Free continuing Nursing Education (CNE) and Continuing Education Units (CEU) will be available for this on-line course. The on-line course is expected to be available to the healthcare industry in December 2012. Once the on-line course is launched, we plan to create location/occupation (e.g. psychiatric and emergency departments, nursing homes, social services, home healthcare, and emergency responders) specific modules that will address workplace violence prevention strategies that are of particular concern for workers in these high risk locations or occupations. Each of these six modules will be designed with the same interactive features as the original course. We will offer an additional hour of free continuing education units for successful completion of each location/occupation specific module.

Implications

Training is an essential aspect of all workplace violence prevention programs. The on-line workplace violence prevention best practices program for nurses can be utilized for employee workplace violence prevention training that should occur when the employee is hired and for annual refresher training.

Learning objectives

1. To describe the components of the workplace violence prevention on-line course.
2. To list the high risk locations or occupations.

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The tendency to manipulate others as a negative personal quality of the doctor

Poster

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Focus: Research

Abstract

It is commonly known that the representatives of the medical profession have high moral and ethical requirements, the combination of sensitivity and empathy, communicativeness and goodwill. At the same time to the characteristics that hinder the success in this profession are attributed such qualities as, hostility, aggressiveness, authoritarianism, tendency to use people to meet one's own needs. In this context, it seems that the high degree of proneness to manipulate others may be regarded as a very negative personal quality of a professional doctor. It is desirable to diagnose and correct it during the training for their future profession.

At the same time, the manipulation can be considered as a form of covert violence. The use of the manipulations is often justified by the fact that they are replacing an open aggression and overt violence. However, they do not change their content, while remaining essentially violent. One can add that this is a more sophisticated form of violence, as it affects the subconsciousness of the person, regardless of the true desires and intentions of this person. The person can not immediately understand that he is manipulated (this is the sense of the manipulation), but eventually starts to realize it. The person, who has become the victim of the manipulation, feels cheated and tries to stop communicating with the offender.

The aim of the study was to examine the propensity for the manipulation of the medical university students. The study involved 30 men aged from 19 to 22 years. We used testing, conversation.

The results showed that the future doctors have a wide gap between their own behavior and the one desired from the others. For the students with a strong propensity for the manipulation is characteristic an active desire to be ‹included› and to be among the people as often as possible. They strive to be leaders, to control everything and influence others, to take over the leadership and decision making for themselves and others, but try to avoid the influence from them. Thus, the communication becomes one-sided and may break the necessary dialogue between doctor and patient. It is obvious that the prevention of the manipulative behavior in medical students is an important task, which can be effectively addressed only with the knowledge of the main reasons for its formation.

Learning objectives

1. To demonstrate the importance of the dialogue between doctor and patient.
2. To demonstrate the importance of the doctor's psychological qualities formation in the period of his professional training.

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Staff nurse education and skill building in the American Nurse Association Conflict Engagement Profile Program

Paper

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Focus: Education and Training
Keywords: Conflict, conflict engagement, nursing practice, operationalizing, safety

Introduction

In the US, The Joint Commission accrediting agency states that health systems must address disruptive behaviors in the workplace. Sentinel Event Alert #40 – Patient Safety and Quality Care, issued in 2008, underscores the role of intimidating and disruptive behaviors in fostering medical errors, poor patient satisfaction and preventable adverse outcomes. One recommendation for addressing disruptive behaviors that undermine a culture of safety is to improve communication between providers.[1,2] Conflict is inevitable in the high stress world of healthcare. The skills to be an effective communicator in a conflict situation are now more important than ever.[3,4] No longer can conflict skill training be reserved for formal leaders. Nurses practicing at the bedside encounter conflict daily.

The costs of destructive conflict in nursing have been well documented and include a negative effect on work environment, teamwork, patient safety, and job satisfaction.[5,6] Data from the Center for American Nurses on-line Conflict Resolution Survey states that 53% of nurses reported conflict as *"common"* or *"very common"*.[7] Lateral (nurse-nurse) and hierarchical (nurse-manager and nurse-physician) conflicts were the most common. The problem is that while nurses frequently encounter conflict, staff nurses consistently use avoidance or accommodation in response to conflict arising in the workplace.[8-11] A majority of conflict issues are not fully explored and no opportunity exists for developing creative, collaborative solutions.

The infrequent use of more assertive, constructive conflict engagement strategies is not unexpected in nurses. There are numerous social and cultural influences that have defined the nurses' role as inferior to physicians, and nurses' position within organizations as powerless to effect change. These influences include 1) the traditional hierarchy of control by medicine in health systems,[12] 2) historical issues of disruptive physician behaviors,[13] 3) a phenomenon of nurses *"eating their young,"*[14] and 4) gender inequality[11]. Brinkert[5] suggests that nurses need to reframe their negative perceptions of conflict and become more open to addressing conflict, in the interest of advancing the nursing role of Advocate in the institutional, interprofessional and interpersonal context. The challenge is to foster this culture shift by effectively operationalizing a program to improve communication in conflict situations.

American Nurses' Association Conflict Engagement Profile Program

For most people, including nurses, 'conflict' connotes an adversarial confrontation, for which there is likely to be retribution; therefore, conflict is to be avoided. In contrast, conflict, as defined in the Conflict Engagement Program, is any situation in which people perceive themselves to have incompatible goals, interests, principles and reactions.[15] The clear difference in these definitions is the added role of perspective. Once perspectives are identified, they can be challenged and negotiated to create a more encompassing and compassionate view of potential resolutions. Not all conflict can be individually managed or resolved, but when a conflict situation is causing personal distress, a staff nurse can use constructive strategies to make the conflict visible and clarify the conflict issues to promote collaborative practice.

The Dynamic Conflict Model[16] depicts the conflict engagement process as beginning with a precipitating event that places the viewpoints and interests of two or more people in opposition to one another. The precipitating event triggers a person's *"hot button(s)"*, which elicits strong negative emotions (see Table 1). How a person responds to an emotional trigger will determine if the conflict becomes Task-Based or Relationship-Based.[17,18] Task-Based conflict resolution focuses on problem solving to work through a conflict issue in which there are differences in perspectives, or opinions. The use of constructive strategies tends to de-escalate conflict by keeping the focus on ideas rather than personalities. In contrast, Relationship-Based conflict focuses on the people involved, often with the purpose of defending one's interests and/or finding someone to blame. Relationship-Based conflict is frequently emotionally charged, and the destructive responses employed tend to increase tension and escalate disruptive behaviors. Ultimately, the Relationship-Based approach has the potential to derail the problem solving process and may lead to avoidable negative outcomes.

Table 1: Responses to Conflict

Hot Buttons	Constructive Responses	Destructive Responses
Unreliable	Perspective Taking	Winning at All Costs
Overly Analytical	Creating Solutions	Displaying Anger
Unappreciative	Expressing Emotions	Demeaning Others
Aloof	Reaching Out	Retaliating
Micromanaging	Reflective Thinking	Avoiding
Self-Centered	Delay Responding	Yielding
Abrasive	Adapting	Hiding Emotions
Untrustworthy		Self-Criticizing
Hostile		

The Conflict Engagement program provides three levels of interactive instruction. Level One is an on-line education program to increase knowledge of workplace conflict and improve awareness of inevitable, everyday conflict. Level Two is an 8-hour skills training workshop. At the start of the workshop participants complete the Conflict Dynamic Profile-Individual (CDPI) instrument,[16,19] which engages participants through immediate, graphic feedback on what provokes the person (Hot Buttons) and how they usually respond to conflict (Constructive and Destructive responses). Level Three group coaching sessions, via tele-conference, reinforce learning and address specific challenges to using constructive conflict engagement strategies.

Modification of the ANA Conflict Engagement Program

Operationalizing the ANA Conflict Engagement Program necessitated modifications to address the need to take staff nurses off a unit to participate in the workshop, and to incorporate practice of new skills over an extended period of time. The modified program includes the online education module, a four-hour workshop, and four one-hour practice sessions held monthly. The practice sessions were named *"Learning Circles"* (LC) and offered two to three times on a designated day each month. Learning Circles were framed as the beginning of a journey to develop and/or enhance conflict competence. Facilitated by a project team member, the LC format is detailed in Table 2. Each LC incorporated social learning activities to enhance participant engagement, foster a sense of community and build trust among the participants. The sessions allowed for time flexibility and were responsive to the needs of the participants.

Table 2: Learning Circle Format

Session	Topic	Activities
One	Perspective Taking	"Ah ha" moments since workshop
		Review of Perspective Taking as a constructive response
		Conflict situation presented followed by role play of "Perspective Taking"
		Debriefing of the role play by group
		Homework plan for next LC: Hot Buttons
Two	Hot Buttons	"Ah ha" moments in your journey
		Sharing of participants' experiences with hot buttons
		Conflict situation presented followed by role play to identify hot buttons and cooling responses to hot buttons
		Debriefing of the role play by group
		Homework plan for next LC: a) commit time to work on individual's action plan to decrease use of a destructive response(s) and b) bring personally experienced conflict scenarios to next session for role play
Three	Destructive Responses	"Ah ha" moments in your journey
		Sharing of participants' experiences with conflict with a focus on: "What did you feel? What did you want to do? "
		Sharing of participants' experiences with conflict
		Volunteer conflict situations presented with role play of destructive behaviors and constructive responses
		Debriefing of the role play by group
		Homework plan for next LC: a) commit time to work on individual's action plan to increase use of a constructive response(s), b) bring personally experienced conflict scenarios for role play, and c) reflect on what will be next steps in your journey to becoming conflict-competent.

Session	Topic	Activities
Four	Constructive Responses	"Ah ha" moments in your journey
		Sharing of participants experiences with conflict
		Volunteer conflict situations presented with role play of destructive behaviors and constructive responses
		Debriefing of the role play by group
		Sharing of identified next steps by each participant
		Review of the advantages and disadvantages of the Learning Circle format

Program Evaluation

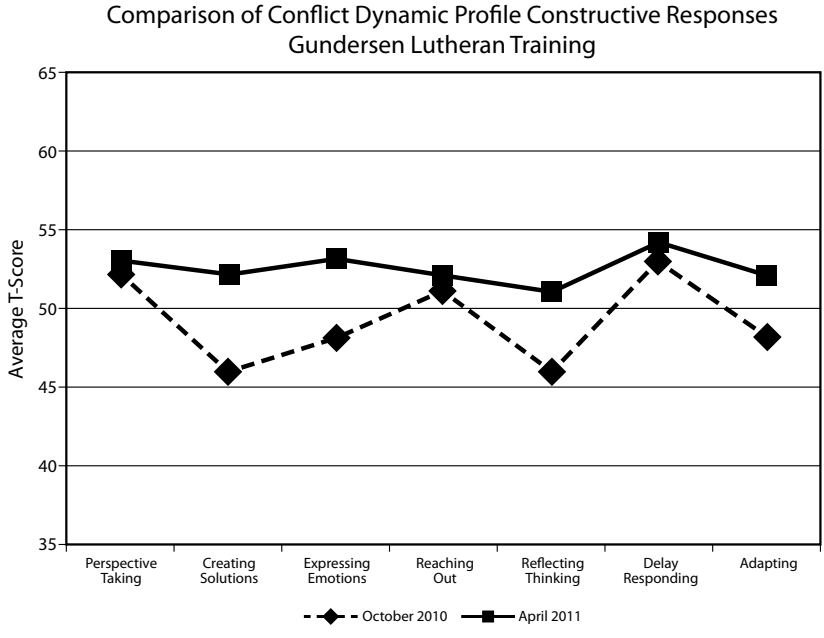
This project was conducted at a mid-size integrated health system serving a rural tri-state area in Southwest Wisconsin, USA. Data were collected from pre-workshop focus groups, a quality evaluation of the workshop, a demographic survey, the pre-workshop CDPI and a CDPI completed six-months following the workshop, and facilitator team meetings. Participants were 45 staff nurses from the hospital (58%) and the clinic (42%) who had been awarded a designation as a nurse expert leader. Fifty six percent of nurses were bachelor degree prepared and 58% were currently active in the system's shared governance structure.

Nurse expert leaders represent nurses who aspire to a high level of professional nursing and are motivated to be at the forefront of nursing practice. Compared to a general population of nurses, members of this cohort are more likely to engage in this skill development intervention and less likely to drop out of the program. As informal leaders, this cohort is expected to frequently encounter and constructively engage in unit-level conflict.

Results

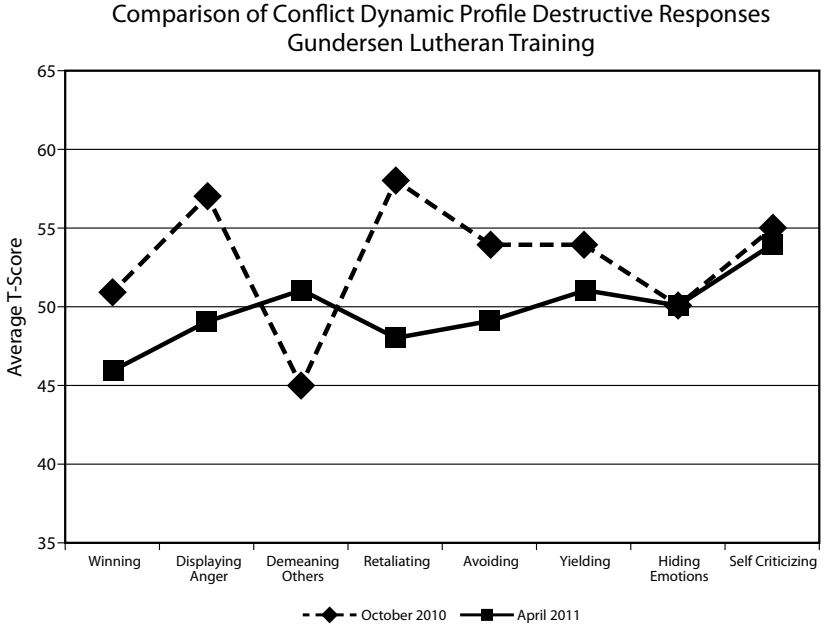
In the pre-workshop focus groups, nurses were not able to state a definition of conflict. Nurses provided specific examples of past and recent conflicts. The lack of understanding of the nurses' role and scope of practice frequently contributed to interdisciplinary and interdepartmental conflict. Workarounds are created to avoid addressing conflict with another person regardless of whether the person is an authority figure or a peer. Participants required a base level of trust and respect in order to engage in conflict due to a fear of retaliation. The exception to this view was any case in which the failure to address an identified conflict had the potential to adversely affect patients' safety. Generational differences contributed to work conflict. Seasoned nurses provided vivid examples of being bullied in the past, while affirming their own commitment to not *"eating our young"*. Although participants acknowledged that conflict could be constructive, very few examples were presented.

Figure 1: Change in Constructive Responses



Nurses' CDPI baseline scores, which identified their 'hot buttons' and most frequent conflict engagement strategies, were comparable to CDPI data from across the nation, and indicated a tendency to Avoid, Yield, and Self-Criticize in conflict situations, rarely Thinking Reflectively or Creating Solutions (See Figure 1 and 2; October, 2010). Six months after the workshop, a trend toward small positive change in behaviors was demonstrated for most constructive and destructive strategies (See Figure 1 and 2; April, 2011). Among the destructive strategies there were three exceptions. Lack of change in Hiding Emotions and Self Criticizing was not surprising because these responses were not covered in the time allotted for the LCs. Discussion with LC participants suggest that the surprising shift toward more frequent use of Demeaning Others may represent participants' increased awareness of responding in this way. In the pre-workshop CDPI, participants may have dismissed the Demeaning Others behaviors as *"I never do that!"* only to acknowledge this behavior after reflection on their own contributions to destructive conflict.

Figure 2: Change in Destructive Responses



Lessons Learned

During the first LC, participants reported being embarrassed by their unexpectedly frequent personal use of destructive responses to conflict. In particular, none of the nurses would have previously acknowledged their use of Winning at All Costs strategies. However, as they reflected on the Winning at All Costs behaviors, they admitted: *"Yes, I do that…and that"*. This experience was very sobering for the nurses. Supported by discussion with their peers, who also admitted use of destructive strategies, the dialogue shifted from Criticizing Self (another destructive strategy) to a commitment to be better at conflict. The CDPI pre-workshop assessment raised personal awareness.

The role-play was uncomfortable for many participants. Initially, nurses did not want to portray the *"bad guy"* in conflict. During the last two LCs, when a participant brought a conflict scenario to practice, they actively sought the role of the person precipitating conflict, demonstrating vividly how they perceived that person's uncivil behaviors as escalating the conflict.

Uncivil behaviors and incivility in the work place are not specifically addressed in this program. However, nurses reported that uncivil actions often triggered their hot button response. Participants voiced that increasing awareness of their own, and others' hot buttons made a difference in their approach to conflict. Another limitation of this program is a lack of emphasis on the skill building needed to manage strong negative emotions evoked by uncivil behaviors.

Skill building occurred over time. At the 4th LC, participants began to acknowledge how their behaviors, in contrast to *"another's"* behaviors, contributed to conflict and/or the escalation of conflict. At the 4th LC, several participants voiced their personal commitment to continuing this self-reflective practice by adding skill building

in conflict as a personal goal in their performance review. A next step for many participants was developing a plan for continuing to connect with each other as a support community when they find themselves in a difficult conflict situation.

Participants strongly recommended the need for additional LCs to build their competency in constructive responses and support their engagement in conflict. At the end of the program, nurses viewed this work as the start of their journey to conflict competence, such that they were beginning to see conflict as an occasion for creative problem solving and innovation.

Discussion and recommendations

Six months is a short period of time in which to change an entrenched culture of conflict avoidance. A strength of this program is its focus on behaviors, which, in contrast to beliefs, are visible manifestations of conflict that can be identified and addressed in a Task-Based conflict engagement approach. The conflict-competent person, through acknowledging his or her own behavioral response or another's behavioral response can set the stage for Perspective Taking. *"I see that you rolled your eyes to my statement…tell me, what do you see as the issue?"* In addition, the focus on behaviors in this program raised both the participants' consciousness of the prevalence of uncivil behaviors in the health care setting. A growing body of literature on civility in the workplace links stress with incivility.[11,20] If the concept of incivility as a precipitator of conflict is incorporated into the Conflict Engagement Program, supporting this work with resources for emotion management and the use of effective coping strategies may increase nurse willingness to actively engage in day-to-day conflict.

Conflict exits everywhere. It is inevitable and yet little time in the workplace is allotted, let alone designated, for building skills needed to use conflict for creative problem solving or innovation. Research indicates that Task-Focused conflict engagement is more likely to resolve a conflict and be experienced as a positive interaction.[17] In the lived world of health care, Relationship conflict almost always accompanies Task-Based conflict. Relationships built on trust and respect will support open communication in conflict situations. Perspective Taking underpins the process of building trust in the conflict engagement program. Miscommunication conflict and conflict arising from an uncivil action may be quickly resolved using the constructive conflict engagement strategies. Conflict Engagement, however, is only one of many tools to promote clear communication in the workplace and a beginning step in a journey to becoming conflict competent.

Operationalizing Conflict Engagement programs within systems is challenging and occurs over time. The organizational goal needs to be a shift in culture toward a more civil work environment in which disruptive behaviors are not acceptable and safety issues are always identified and addressed. One program will not change a system, nor will it be effective in improving all communication. Organizational vision and readiness are vital to change. Findlay and Verhoef suggest that readiness may be both a state and a process.[21] While conducting the LCs, the team quickly recognized the various degrees of readiness among participants: not only readiness to engage in conflict, but readiness to look at one's own role in the escalation of conflict, and to engage in Perspective Taking. For many participants this personal insight occurred between the third and fourth LC, at which time they were more open to test out new skills and to see possibilities for continuing this journey to be a better person. The vision of the Chief Nursing Officer has been instrumental in continuing to move the Conflict Engagement program forward and support its alignment with other system conflict management/communication programs (see Table 3). The continuing goal is to build a community of nurses who can model and mentor others in constructive conflict. An ensuing goal is to provide opportunities for inter-professional leaders to co-create the culture shift to a healing environment in the clinical setting.

Table 3: Programs offered at Gundersen Lutheran

Program	Description	Website URL
Achieve Global (Hardwiring Excellence)	Performance feedback conversation training for managers.	www.achieveglobal.com
Conflict Engagement	Training program for self-awareness and development of communication skills using tools from the Center for Conflict Dynamics at Eckerd College.	www.conflictdynamics.org
Crucial Conversations	A leadership training program for developing communication skills.	www.vitalsmarts.com
Culture of Patient Safety (Pascal Metrics)	Program designed for the peri-operative areas to create a safe environment for communication to improve patient safety.	www.pascalmetrics.com
Crisis Prevention Institute	Patient and staff safety program. The primary purpose is to provide tools to avoid the escalation of issues into dangerous situations.	www.crisisprevention.com
HeartMath	Program used to center yourself in stressful situations. Any situation where your physical reaction might interfere with your brain being able to process clearly. "Revitalizing Care" = Self-care for the care giver.	www.heartmath.com
Employee Assistance Program (EAP)	Provides assessment, consultation and referral if appropriate to employees dealing with conflict in the workplace or in other areas in their life. Employees either self-refer or are referred as part of a coaching or Performance Improvement Plan (PIP).	www.gundluth.org/eap

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Learning objectives

1. Participants will be able to describe the Conflict Engagement Profile program for use in the clinical practice setting.
2. Participants will be able to discuss the importance of civility and the Concept Engagement program in building a culture of conflict competence.

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Working with the Structured Assessment of Protective Factors for violence risk (SAPROF), instrument for the assessment of protective factors in (forensic) clinical practice

Workshop

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Focus: Education and Training

Abstract

This Seminar comprises an extended 3-hour SAPROF workshop.

A variety of tools have been developed for the prediction and management of future violence and offending. Most, however, largely ignore the presence of protective factors that may reduce the likelihood that an individual will (re)offend (Rogers, 2000). The Structured Assessment of Protective Factors for violence risk (SAPROF; De Vogel, De Ruiter, Bouman & De Vries Robb, Dutch Version 2007; English Version 2009) is an instrument for the assessment of protective factors. It is a structured professional judgment checklist designed to be used in combination with other structured risk assessment instruments like the HCR-20 (Webster, Douglas, Eaves & Hart, 1997). The addition of the structured assessment of protective factors aims to complement the risk assessment process creating a more balanced assessment for future violence risk. The dynamic factors of the SAPROF can be helpful in formulating treatment goals, evaluating treatment progress and stimulating positive risk communic ation. In doing so, protective factors enable a more positive approach to violence prevention. Previous research results with the SAPROF in samples of violent and sexually violent offenders showed good interrater reliability and good predictive validity for no violent recidivism after treatment and no violent incidents during treatment. Moreover, SAPROF scores showed significant improvements during treatment and the positive development of protective factors during treatment proved predictive of less violent recidivism.

This workshop will focus on the additional value of protective factors for clinical practice. Participants will be introduced to the SAPROF and will gain first hand practice working with the instrument. Advantages for risk assessment and risk management will be discussed and new clinical research results with the SAPROF will be presented.

Learning objectives

1. To gain better understanding of protective factors and their utility in risk assessment and management
2. Learn about how the assessment of protective factors may enhance case formulation and planning, and risk communication
3. Learn about the development of the SAPROF
4. Practice working with the SAPROF
5. Learn about the growing research findings about SAPROFs predictive validity and inter-rater reliability
6. Learn about using structured professional guidelines in clinical practice

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Safety and Violence Education (SAVE): A novel web-based interactive learning environment for healthcare workers

Paper

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Focus: Education and Training
Keywords: Violence, risk, mental disorder, connected learning, competence, capability

Introduction and background

Healthcare professionals routinely encounter challenges to their personal safety. Unfortunately, few of these staff have undergone training to effectively minimize workplace violence risk or to prevent violent situations within their clinical care settings. Although serious incidents of violence against healthcare workers remain relatively low, fallout from their occurrence tends to inspire staff and agency reactivity, and further stigmatizes select populations of patients, such as those with mental health disorders. Workplace violence impacts staff morale, recruitment and retention, and ultimately the quality and delivery of patient care. Witnessing violence can also contribute to feelings of helplessness, loss of control and predictability in the workplace. Proper safety and violence prevention training can assist in mitigating such violent patient-provider encounters and impact of such incidents on staff retention (1).

Effective onsite training solutions are desired, but barriers exist including challenges in gathering large groups of busy healthcare professionals (time efficiency), financial constraints (cost efficiency) of their organizations and beliefs that patient service delivery supersedes practitioner safety. Another limitation of onsite training can be training efficiency. Effective training and knowledge acquisition is dependent upon many variables including the quality and experience of the instructor; instructional methods; lack of standardization and consistency; lack of personalized learning and limited ongoing access to training resources. As the demand for safety and violence prevention training continues to grow, new solutions are needed that can offer more flexible and cost-effective alternatives to traditional onsite training.

Based on the needs of a local community mental healthcare facility that engaged at-risk individuals with mental disorders, the Safety and Violence Education (SAVE) curriculum was initially developed in 2001. In 2004, the Safety and Violence Education (SAVE) program was chosen as mandatory training for the rollout of over 74 New York State mental health Assertive Community Treatment teams, and was sponsored by the New York State Office of Mental Health. Through foundation grant support, the Safety and Violence Education (SAVE) training gained more regional and national exposure via production of a user-friendly and self-study designed CD ROM interactive educational tool (1).

Since the unparalleled expansion of Internet systems to disseminate learning, and the widespread acceptance of technology-based solutions (e-learning) in professional development and corporate training, e-learning is rapidly becoming the catalyst that is changing the model of learning in the 21st century (2). E-learning is an approach to teaching and learning, representing all or part of the educational model applied, that is based on the use of electronic media and devices as tools for improving access to training, communication and interaction and that facilitates the adoption of new ways of understanding and developing learning (3).

Evidence suggests that e-learning provides a more efficient format because learners gain knowledge, skills, and attitudes faster than through traditional instructor-led methods (4). Other reports indicate that technology-based training has proven to have a 50-60% better consistency of learning than traditional classroom learning because students have more control over their learning process (5). Schools, universities, medical centers and corporations are embracing the many compelling benefits that e-learning offers, including: anywhere-anytime learning; flexibility of content delivery; more diverse, engaging, interactive learning experience and the ability to combine different learning styles to enhance and personalize the learning experience.

Furthermore, the e-learning format promotes 24/7 access to knowledge and learning resources and customization of learning to the healthcare workers needs. In addition,it is easily updatable to change or modify learning content and a more efficient option to monitor and track learning performance and outcomes. Ultimately, e-learning offers better knowledge sharing and collaboration, improved consistency and standardization of training materials and a potentially more cost-effective training approach. As such, development of an e-learning application emerged as the logical next step for the SAVE curriculum. This paper will describe the next generation of SAVE; an online violence prevention training program for workers in the health sector.

Methods

The primary objectives of the SAVE Training approach are two fold: (1) To build competence (knowledge, skills, attitudes) of evidence-based safety and violence prevention practices among health care workers, and (2) to build capability, and the capacity to adapt one's skills and knowledge to meet new and ever-changing situations and continuous performance improvement. The primary components developed to achieve the SAVE Training program objectives include:

1. User Profile. The User Profile serves the following functions: a) provision of a more responsive learning experience by gathering specific information regarding user demographics, prior safety training experience, job title and duties, and past exposure to workplace violence. This information is used to provide a more tailored and responsive learning experience for the user and allows a better matching of relevant case studies and skill building exercises. For example, a case manager who spends a lot of time doing outreach work in the community may be presented with different case studies and training exercises compared to a psychiatrist who operates primarily within a clinic setting, and b) creation of a user registry/database for further study of the efficacy, impact and future needs of the training program.

2. Pre and Post Learning Assessments. These assessments serve to ascertain the user's workplace violence knowledge base prior to the accessing training and information learned following the SAVE training. This also serves as a mechanism for certification of successful program completion.

3. Learning Modules. These self-directed modules represent the primary training content for SAVE representing following key topics:

- Understanding risk factors for violence
- Using interpersonal skills (verbal and nonverbal) to prevent and deescalate crisis
- Safety precautions for transporting individuals
- Patient encounter safety utilizing Situational Awareness
- Staff well-being promoting retention and recruitment
- Developing an agency/ward safety plan

   The learning modules include the following formats: video-based teaching, interactive skill-building and reflective exercises, FAQs, animated vignettes and interactive case studies of practicing healthcare professionals. These case studies contain real-life testimonials of violence in the healthcare setting and support both skill building and reflective exercises. Self-assessment tools and knowledge checks are integrated throughout the course to reinforce topic content, provide specific user feedback and facilitate learning effectiveness.

4. Virtual Learning Community (VLC). Along with the self-directed learning modules comprising the SAVE training, users also have access to a Virtual Learning Community (VLC). The VLC is designed to promote a flexible and lifelong learning environment where peers (registered users) can share and exchange experiences, discuss problems, pose new ideas and workplace violence prevention strategies. The ultimate aim of the VLC is to create a dynamic collaborative learning environment and bring the advantages of *"collective wisdom"* into play. Collective wisdom is created and fostered by the contribution of user knowledge sharing and experiences to support a common purpose.

Results

A four-step SAVE Training Process has been developed to guide and inform users to minimize their risk of workplace violence (see diagram 1). This process creates a practical method and simple strategy for users to employ in their daily clinical routines to achieve this objective. Although workplace violence incidents may be relatively rare in the health sector, it is recommended that these steps be considered for all provider-patient interactions. The following elements of the process are described below:

1. *Gather information*
   Information relative to an individual's risk for violence may be gathered from many sources. Assessing potential risk factors for violence begins by gathering relevant information about each individual. Such information, after obtaining appropriate release, may reside within patient medical records, criminal justice reports and from collateral informants. Informants can include, but are not limited to, other clinicians, caregivers and family members.

2. *Analyze Information & develop proactive management strategies*
   Users will be instructed to consider the information gathered to develop a risk profile for each patient that they will encounter. Weighing the risk factors for violence versus the mitigating risk factors will be discussed and used to assist in the development of this profile. From this analysis, strategies on patient approach and ultimately provider-patient interactions can be developed.

3. *Client Interaction/Engagement*
   Within this third portion of the training process management strategies are shared promoting safe practice during patient engagement. The details include methods for reducing the likelihood of escalating a violent

interaction, preparation of the user's work environment and verbal/nonverbal de-escalation techniques. A key portion of this step is an ongoing emphasis on limiting any physical interactions with a potentially agitated individual along with the development of crisis notification and appropriate exit strategies.

4. *Debriefing/Documentation and Reflection*
   Within this final step of the SAVE training process, users are instructed on relevant review following a high-risk provider-patient interaction. This process can be accomplished in several ways including a rapid team debriefing that allows reassessment of a particular interaction, recording of any instances of workplace violence along with the steps taken that reduced or aggravated that provider-patient engagement. Finally, documentation of these interactions can then be used both for further incident review, quality improvement processes and reinforcement of safe practice strategies.

Diagram 1. SAVE training four-step process

Discussion and Conclusion

The desired outcomes of the SAVE Training program can be summarized by the following 3 goals:

1. To provide an efficient and effective method to train more healthcare workers. With the adoption of a customizable e-learning format, SAVE Training now has the potential to reach larger and more diverse healthcare audiences such as those working in emergency and paramedical services, correctional settings, residential and extended healthcare environments.

2. To promote a sustainable violence prevention learning environment. It has become increasingly recognized that continuing professional development for healthcare professionals is most effective when there is active interaction and sharing of knowledge between individuals (6). The commitment to safety training should be viewed as a life long process rather than a one time *"training"* event. Staying current is essential to provider competence and capability in a healthcare environment that continues to evolve and increase in complexity (7). The SAVE Virtual Learning Community provides a ongoing dynamic environment where members can stay connected to timely resources and interact with an online community of peers to exchange ideas and solutions.

3. Facilitate future study and evaluation of the training process. Although online instruction for health professionals has increased dramatically and e-learning is believed to provide a bridge between the cutting edge of training and outdated procedures embedded in institutions, the literature suggests more research is needed to focus on the effectiveness of this training modality (8). The SAVE training program offers access to a potentially large and connected healthcare audience. Incorporating a research database within the SAVE program will facilitate review of training effectiveness, trainee satisfaction and user feedback.

Further study is required to assess the impact of this novel safety training approach on the prevention of violent interactions among healthcare workers globally.

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Learning objectives

1. To describe the development of a novel, web-based, interactive learning environment for violence prevention training in the healthcare sector.
2. To explain the interactive assessment process of the SAVE training that both identifies and addresses the unique knowledge and practice needs for each end user.

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The perception by undergraduate nursing students of de-escalation training experience

Paper

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Focus: Education and Training
Keywords: De-escalation training, workplace violence, safety, violence

Background

Daily, the public is inundated with reported incidents of violence around the world, both of an individual and group nature. Living with violence as an element in our environment has become the norm (Rippon, 2000). Research indicates that this is now true in the health care work setting impacting health care workers, patients and their significant others. In 2009, there were 2,050 assaults and violent acts reported by nurses requiring an average of 4 days away from work. Of these nonfatal assaults, 89% were injuries inflicted by patients or residents and 4% were inflicted by visitors or people other than patients. The causes of these reported injuries to nurses requiring days away from work were as follows: 25% were hit, kicked or beaten, 6% were squeezed, pinched or scratched and 2% were bitten (Bureau of Labor Statistics, retrieved 2011). Healthcare workers are at 16 times greater incidents of violence than the general public (Anderson, 2006). Between 2003 and 2009, of eight registered nurses fatally injured at work, four died from gunshot wounds that lead to their death and four from other causes (BLS, retrieved 2011). All eight of these nurses were working in private healthcare facilities, not state or government facilities. The U.S. Occupational Safety and Health Administration (OSHA) and the National Institute for Occupational Safety and Health (NIOSH) define workplace violence as *"violent acts (including physical assaults and threats of assault) directed towards persons at work or on duty"* (NIOSH, 1996). Following September 11, 2001, OSHA and NIOSH (2002) revised the definition to read *"violent acts include assaults, and threats of assaults directed towards persons at work or on duty. This includes terrorism."* More recently, the American Association of Occupational Health Nurses (AAOHN) in collaboration with the Federal Bureau of Investigation (FBI) defined workplace violence as *"any action that may threaten the safety of an employee, impact the employee's physical or psychological well-being , or cause damage to company property"* (AAOHN, 2003). With this broader definition of workplace violence, the Bureau of Labor and Statistics reports (retrieved 2012) that 45% of nonfatal injures from violent acts against workers occurred in the health care environment.

In addition, lateral violence and bullying have been identified as two types of disruptive behaviors present in the work setting. Lateral violence in health care settings is defined as nurse to nurse aggression. These behaviors may include backstabbing, verbal abuse, sabotage and withholding information. Bullying in the health care setting is defined as insulting or malicious behavior or abuse of power causing an individual to *"feel threatened, humiliated or intimidated, causing the person to feel stressed and contributing to the loss of self-confidence"* (Center for American Nurses, retrieved July 9, 2012). There are many reports of both the occurrence of lateral violence and bullying and the negative impact of these behaviors on patient outcomes, healthcare personnel and employers.
Nurses are the most common victims of workplace violence due to the high numbers of nurses on the frontlines of healthcare provision (Smith-Pittman & McCoy, 1999). Perpetrators of workplace violence are most commonly male and patients (Rosenthal, Edwards, Rosenthal & Ackerman, 1992). Physicians may be perpetrators (Manderino & Berkey, 1997), but threats of harm and actual physical assault by physicians appear uncommon. Nurses most commonly abuse other nurses (Anderson, 2002a, 2002b; Center for American Nurses, retrieved July 9, 2012).

The cause of workplace violence is neither simple nor one dimensional. It is recognized that healthcare workers function under high levels of stress. Whether in hospitals, clinics or home environments, there are co-workers, patients, patient family members, visitors or intruders potentially contributing to violent events in the healthcare environment. Other factors include the increase incidence of drug and alcohol use, weapons, poor coping skills, long wait times for patients, unrealistic expectations of health care providers by patients and families and compromised cognitive and social functioning skills of patients due to psychological changes such as dementia and psychosis. Other factors potentially impacting the increasing incidence of workplace violence include organizational structure deficits, omissions or limitations in the areas of policies, procedures, management and staffing. In combination, all the above factors make workplace violence detection and prevention difficult. Additionally, the links between stress, conflict and violence are known. However, organizations rarely prepare healthcare workers to recognize, prevent or manage potential workplace violence.
A comprehensive and multifaceted approach to workplace violence in the healthcare setting is essential. No plan to address workplace violence will be effective unless professional organizations, healthcare facilities and personnel, plus communities support these efforts. Not only must healthcare organizations and facilities provide the means to create and maintain safe work environments for the provision of healthcare, healthcare personnel must be able to recognize, prevent and/ or safely manage these events to decrease the effects of violence (Center for American Nurses, retrieved 2012). Therefore, it is proposed that nursing education must contribute to the creation of safe workplace environments by preparing future nurses to recognize, prevent and/ or manage violence in the workplace.

By history, nurses perceived violence as integral to the provision of healthcare to the acutely ill inpatient psychiatric patient (Cowman and Bowers, 2008). Many of these incidents were the result of patients being acutely ill, confused and/ or psychotic. However, education of direct care personnel in these settings in the assessment, prevention and management of violent events has been in existence for many years resulting in reductions of patient and staff injuries associated with workplace violence. It now is standard practice for staff to receive training in de-escalation techniques and management of the violent person. However, this training has not consistently extended into other healthcare settings. Training and education of front line health care providers are major elements in an effective organizational safety and security program.

Research on the need for and implementation of training programs to reduce workplace violence indicates an uneven and non-uniform implementation strategy. Anderson (2006) reports the implementation of an online training program on workplace violence as a means of addressing workplace violence for health workers at a small community hospital. The study implemented a three hour online training program aimed at decreasing the incidents of violence with no significant differences. However, the need for training of personnel to address workplace violence is identified. Other research found de-escalation training significantly improved nurses level of confidence (p=.007) in managing an aggressive or violent patient when compared to untrained nurses (Cahill, 2008). For this study, communication skills were the core of the training program with emergency department nurses. However, no significant difference was found for changes in attitudes towards managing the aggressive or violent patient associated with training.

The need for a zero tolerance policy for violence in the healthcare workplace is a common theme for writers. Gallant-Roman (2008) identified the necessary components provided to health care workers to identify, prevent and manage violence in the workplace. These include the empowerment of nurses to recognize and not accept violence as part of their professional practice. Clements et al (2005) speaks to the need for corporate policy in the implementation of zero tolerance workplaces. However, the authors are focused on the effects of violence and the needed intervention post violent incident. A Journal of Hospital Home Health editorial (January, 2010) reiterates the need for organizational support and intervention through the use of policies and education and training with staff to create a *"safe"* work environment.

Words alone will not create this environment but action is needed by healthcare organizations to create a safe work environment. An approach of zero tolerance to violence by patients in the healthcare setting in Britain served to identify the need for an organized method of managing the violent clinic patient (Paniagua et al , 2009). With the implementation of zero tolerance, the identified violent patients were assigned to a separate clinic. The authors report this model of care is subject to bias, abuse and miscommunication as to whether the patient is a *"victim"* as when their behavior is a result of their health state or as a *"problem"* when their behavior results in the inability of the provider to deliver care or violates the rights of others. All staff is provided de-escalation training in the clinic for violent patients. The authors stress the need to better address the cause of violence as well as better prepared staff to identify and manage aggression and violence in the healthcare setting.

Early entry into negative or harsh work environments may contribute to the development of negative attitudes towards work itself (McDowell& Futris, 2003 reported in Center for American Nurses, retrieved July 14, 2012). Workplace violence has been found to impact nursing students (Magnavita and Heponiemi, 2011). This study, though limited to Italy, described violent incidents experienced by student nurses and the negative impact of the experiences. Licensed professional nurses reported more physical assaults and sexual harassment primarily from patients and patient's family. Nursing students reported higher incidents of verbal and physical assault from colleagues, staff, teachers, physicians and supervisors. The authors propose that along with organizational changes such as policies, improved staffing and non-tolerance of aggression or violence, staff training to create and maintain a safe workplace is the best method to decrease incidents of workplace violence.

Method

Seventy eight traditional BSN students enrolled in the psychiatric mental health nursing course were provided a one day, six hour de-escalation training program by certified training staff employed at the local state mental health hospital. University IRB approval was received and informed consent was provided by students participating in the training program. Six training sessions were provided each consisting of thirteen students over two semesters. The didactic content included therapeutic communication techniques, stress and its' effects, taking care of oneself, assessment of risk for violence, verbal de-escalation techniques and physical interventions to minimize injury. At the start of the training session, A hardcopy of the training slide show presentation was provided to each student at the start of the class. The four hour class time was followed by two hours of rehearsal or simulation allowing students to practice learned intervention technique. No student refused to participate in the simulations. At the end of the class time, students were asked to participate in an evaluation of the de-escalation training session. The evaluations (n=76) were anonymous and did not affect the student's grade or performance in the course. The evaluation tool consisted of six open ended statements addressing students' identification of learning, the impact of their learning on their clinical practice and what made the learning effective.

Results

Overall, the feedback from students was very positive. Participants found the presentation helpful, important, interactive and fun. One comment stated, *"I really enjoyed and benefitted from this."* Participants noted that the techniques taught in the presentation were very helpful to their practice, day to day encounters and also reported seeing the value in this training to go beyond the workplace. *"{De-escalation training} offers real life strategies*

that can be useful outside of the work environment." Participants reported learning new conflict management skills that would inform their practice going forward. Three themes emerged from the data. First theme that emerged was the sense of empowerment. This theme emerged over and over across questions with statements such as *"I am not a victim,"* and *"I am more confident in dealing with conflict situations."* Participants also noted feeling more aware and more prepared to recognize and handle conflict. Second, participants reported learning new defensive techniques that will help them deal with conflict in a safe and effective manner that facilitates teamwork and protects both the patient as well as the caregiver (staff/ themselves). Third, participants reported having learned new communication techniques that will help them keep and remain calm when dealing with conflict. Several terms were used including redirect, neutralize, and interact to indicate a better understanding of how the two techniques (defensive and communication) can be used together to diffuse or address a conflict situation.

Discussion

With ever increasing incidents of workplace violence, it is critical that health care providers be prepared and able to manage the aggressive or violent situation or person. The healthcare organization intervenes through the development and implementation of *"safe workplace"* policies and procedures. An additional measure to enhance the creation of the safe workplace is adequate preparation of current and future front line personnel. Frontline personnel including providers must be able to recognize, prevent and manage these high risk situations with effective evidence based strategies. The novice nurse entering the workforce can contribute to the creation and maintenance of a safe workplace by being knowledgeable and adequately prepared. This study reported perceptions of de-escalation training by nursing students in creating a sense of empowerment to better manage workplace violence in healthcare settings. The transfer of this perception to the utilization of these new skills and abilities in the workplace needs further research.

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Learning objectives

1. The learner has an increased awareness of the need for de-escalation training.
2. The learner recognises the appropriateness of integration of de-escalation training in undergraduate nursing education.

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Horizontal Violence: An Inner Threat to the Nursing Profession and Health Care Organizations

Paper

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Focus: Education and Training

Abstract

Background

Caring is central core of nursing profession. Interpersonal conflict among nurses is significant issue confronting the nursing profession. Impaired personal relationships between nurses at workplace can cause errors, accidents, and poor work performance. Consequently, it compromise patients care and produce psychological problems in oppressed nurses.

Purpose

The purpose of the study was to determine the prevalence of horizontal violence among nurses, different form of violent behavior at work place and its causes & impacts on nurses and health care institutions.

Design

Systematic review of the last eleven years published literature (2000-2011)

Result

The study revealed that over recent decades there has been growing recognition that workplace bullying is a pervasive and harmful feature of modern workplaces. More assaults occur in the health care and social services industries than in any other sector. Bullying is widespread in nursing and that it can render the workplace a harmful, fearful and abusive environment. It is known that workplace bullying is not a one-off or accidental event; instead, it is a deliberate and ongoing array of often subtle and masked negative behaviors and actions that accumulate over time. Harassment in the workplace has been characterized as a gradual, often invisible and an intensely individualized and harmful experience. Literature revealed that Interpersonal conflict among nurses is significant issue to the nursing profession. It has severe devastating effects on nurses like transmission of violence to other generations, reduced quality of life, loss of self-esteem, increased stress and anxiety, reduced productivity, increased absenteeism, deterioration in the quality of care, low morale, abandonment of the profession and reducing expert staff from the profession and increase in errors at work. The organization suffers because staff lack initiative to do their job well, they use more sick time and staff turnover is increased. Horizontal hostility drains off nurses' energy and undermines the institution's attempts to create a satisfied nursing workforce. There are also more complaints from patients and relatives in these organizations. Research has shown that nurses who report the greatest degree of conflict with other nurses also report the highest rate of burnout. It was revealed that different form of violent behavior like bullying, threats; rude gestures, hostile behavior, squeezing and punching were used as different types of violent behaviors. It was highlighted in the review that to prevent horizontal violence, primary prevention begins with education and training of staff. These concerns need to be considered in all areas of nursing including the clinical workplace, curriculum development of undergraduate programmmes and development of first year of practice orientation schemes supporting new graduates.

Conclusion

To prevent horizontal violence among nurses at workplace, a comprehensive approach should be adopted. This approach should be from the curriculum development for nurses at educational institutes; training and continue educational session at work place.

Learning objectives

1. To sensitize the Nursing Community and leaders of Health Care Organization regarding the horizontal violence and its impacts on health care system.
2. To promote awareness among nurses regarding the issue.
3. To promote my presentation skills and my learning.

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Chapter 17 - Quality safety and risk reduction initiatives

Framework for reduction of workplace violence in hospitals

Workshop

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Focus: Organisational

Abstract

Background and context

Violence towards hospital workers can adversely affect employee safety, health, work productivity, retention, and the quality of care. However, hospitals lack practical and sustainable systems for workplace violence surveillance, risk assessment, reduction, and prevention. The objective of this workshop is to present a comprehensive, research-based framework for reduction and prevention of workplace violence in hospitals.

Methodology

The proposed framework is based on years of research and a review of the most current scientific literature on workplace violence in the health sector. Three basic tenets comprise the foundation for this framework: (1) A standardized approach to workplace violence reporting, risk and hazard appraisal, and intervention; (2) A shift from case-based to population-based surveillance, applying epidemiological analysis to a comprehensive reporting system that includes workplace violence along with other occupational exposures; and (3) Reporting, analysis, and prevention of workplace violence should be ongoing and integrated into the normal working life of the hospital. This framework is currently being implemented and evaluated in an ongoing participatory action research project in a large hospital system with 15,000 employees. The project has a mixed-methods design, incorporating both qualitative and quantitative data analysis.

Findings

The following have been identified as fundamental building blocks of the framework: (1) Documentation and surveillance using a central, secure database; (2) Risk assessment based on population-based incidence rates; (3) Prioritization of intervention needs using the Hazard Risk matrix; (4) Fact-based intervention; and (5) Intervention evaluation based on violence incidence and injury rates and employee appraisals.

The comprehensive reporting system and central database should encompass the full spectrum of both physical and non-physical violence from patients, co-workers, and hospital visitors. It should be accessible, secure, and integrated into normal workplace practice at all hospital system worksites. The database should be constructed to enable the calculation of the incidence of specific types of violence; to examine trends in worker reporting of violent events over time; to conduct multivariate analyses to determine risk factors for both physical and non-physical violence; and to evaluate the efficacy of violence intervention efforts. Researchers and hospital system stakeholders believe that this framework will help to counteract underreporting, which is a major barrier to workplace violence prevention efforts. The central database that is currently the prototype for this study also allows researchers to prospectively follow and compare incidence and injury rates of violence wit h corresponding rates of other reported occupational hazards.

Prerequisites for the successful implementation of this framework include (1) An organizational policy that prohibits violent and aggressive behavior and mandates reporting of known incidents; (2) A standardized, incident reporting system that is accessible to all employees; (3) Active management and labor support and involvement.

Each aspect of this framework will be presented and discussed using an interactive approach, encouraging the audience to pose questions and discuss their views.

Implications

This framework represents a standardized approach for the management of workplace violence in hospitals that provides an evidence-based template for the entire risk surveillance, reduction and evaluation process. If effective, the framework could be readily translated and exported to hospitals worldwide.

Learning objectives

1. This local initiative represents a major effort to standardize workplace violence data collection, epidemiological risk analysis, and translation of collected data into effective violence reduction and prevention efforts.
2. Many of the key aspects of the framework presented here have global applicability to all hospitals striving to reduce violence towards employees.

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Workplace violence: The players and the faces

Paper

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Focus: Organisational

Introduction

Regrettably, violence in the health sector is not a new phenomenon. For decades, violence was believed to be *"part of the job"* (Gacki-Smith, J. et al, 2009) and healthcare employees of all types were expected to accept it as such. Nurses and paraprofessional employees faced the highest rates of violence because of the number of hours they spent delivering direct care and dealing with distraught families. As members of caring professions some believed to identify or complain of violence meant you were somehow a failure. Despite the prevailing apathy toward workplace violence the discourse on violence began to shift and for three decades now health care employees have been increasingly vocal, advocating for change and challenging the historical tolerance. Over time unions and legislators have added their voices to the issue and have pushed Health care organizations to begin to seriously addressing the issue of violence. (Registered Nurses Association of Ontario, 2009)

Background

In 2010 Accreditation Canada, a non-profit organization that provides national and international health care organizations with a peer review of their practices using standards of excellence prioritized the issue of workplace violence (WPV). All health care organizations who sought to gain accreditation or maintain their existing accreditation were informed of the new workplace violence, Required Organizational Practice (ROP). ROPs are defined as *"an essential practice that organizations must have in place to enhance safety and minimize risk"* (Accreditation Canada, 2012). This ROP states that *"the organization prevents workplace violence"* (Required Organizational Practices, Accreditation Canada, 2010). Additionally, it urges organizational strategies to comply with applicable provincial legislation.

All Accreditation Canada ROPS include tests for compliance, the Workplace Violence ROP has eight; a) the organization has a written workplace violence policy, b) the policy is developed in consultation with staff, service providers, and volunteers, c) the policy names the individual(s) responsible for implementing and monitoring the policy, d) the organization conducts risk assessments to ascertain the risk of workplace violence, e) there is a documented process in place for staff and service providers to confidentially report incidents of workplace violence, f) there is a documented process in place for the organization's leaders to investigate and respond to incidents of workplace violence, g) the organization's leaders review quarterly reports of incidents of workplace violence and use this information to improve safety, reduce incidents of violence, and make improvements to the workplace violence policy, and h) the organization provides information and training to staff on the prevention of workplace violence(Required Organizational Practices, Accreditation Canada, 2010).

Canadian health care organizations were given the deadline of November 2011 to develop processes to meet the new ROPs tests for compliance. As a client organization, the Health Sciences Centre (HSC), a tertiary health care provider in Manitoba, Canada was required to meet this new ROP to maintain its accreditation standing.

Implementation of Workplace Violence Advisory Committee (WVAC)

In November 2010, the Vice President/Chief Nursing Officer (VP/CNO) developed the Workplace Violence Advisory Committee (WVAC) as a mechanism to meet the new ROP. Early meetings of the WVAC determined the makeup of the committee. It was decided that the committee would intentionally be restricted to five members, to reduce the potential for the committee to become stalled and mired in circular discussions. The composition was interdisciplinary it included a frontline manager with extensive experience in acute mental health care, an occupational environmental, safety and health officer, a security services staff member, a human resources representative and a clinical staff member(Peek-Asa, C. et al, 2009; Zichello, C. et al, 2010; Clements, P.T. et al, 2005). The mandate given to the WVAC was to research, develop and implement a plan that would facilitate HSC meeting the ROP. Additionally, the committee was expected to avoid duplicating work done by other HSC departments while providing a supportive role to all HSC departments.

Initially, the committee focused on developing terms of reference and strategies to satisfy the new ROP. The WVAC first sought to identify the various stakeholders internally and externally and to understand their roles in relation to the issue of workplace violence, it was important to identify where the power to influence change resided. Additionally, it was determined early on that clearly defining the role of the WVAC was of paramount importance. In order for the WVAC to be effective it was agreed it could not take on duties and responsibilities assigned to other departments such as Human Resources (HR) or Occupational Environmental Safety and Health (OESH) (Zichello, C. et al, 2010). Specifically, the WVAC sought to maintain impartiality across the organization in order to conduct assessments and prepare objective reports which would include unbiased recommendations to present to the leadership of the program.

After seven months of meetings the following decisions were made; HR would retain responsibility for complaints reported under the *"Respectful Workplace"* policy, OESH maintained its responsibility for the Respectful Workplace Program which includes the Workplace Safety and Health (WS&H) Regulations on Violence Prevention and the WVAC would be responsible for conducting assessments of programs/departments and preparing reports with recommendations focused on staff safety. The WVAC aimed to remain impartial in order to allow the program leadership to weigh the findings and recommendations against other priorities and to make operationally feasible decisions about addressing these concerns. The WVAC felt the benefits of this approach included; a) availability of an impartial group capable of conducting an objective safety assessment of programs and b) development of a process to advocate concerns from staff through informed recommendations that have the potential to increase the safety of staff.

While the WVAC worked to delineate their role, other tasks were also being performed. The WVAC set about identifying all the various types of violence reports currently in use at the HSC. Several reporting processes were found including: an electronic tool unique to Security Services, a one page template for Reporting Abuse of staff used by HR and the Injury/Near Miss (I/NM) form, an eight page document used by OESH. It was concluded that the I/NM form is not commonly used by staff. Failure to use the I/NM could be due to a multitude of reasons including the following beliefs; violence is part of the job, reporting won't change anything, being a victim may indicate poor job performance or worker negligence and the lack of interest in doing additional documentation and the stigma of victimization (Kling, R. et al, 2009; Gacki-Smith, J. et al, 2009; Clements, P.T. et al, 2005). Based on the completed I/NM forms it seems that staff are more likely to complete I/NM forms when there is a possibility of requiring Workers Compensation Board (WCB) benefits. Additionally, a review of completed I/NM forms suggested staff do not report verbal abuse, bullying, or intimidation with this form.

Despite the absence of research supporting the use of simple data collection tool over a longer more in depth tool, the WVAC lobbied for the *"Reporting Abuse of Staff"* template to be the tool used for data collected rather than the I/NM form. Interestingly, one study that relied on a one page violent incident form (VIF) to provide a practical tool for recoding violence found that at the close of the year long study several work sites continued to use the form. (Arnetz, J.E. et al., 2000)

Since HSC is an operating division of the Winnipeg Regional Health Authority (WRHA) and OESH is a WRHA department negotiations between the site and the WRHA took place to determine which tool would be used to collect workplace violence data. Regrettably, these negotiations delayed the implementation of the WVAC assessments. A full eleven months after the WVAC was formed the decision was made that the I/NM form would be the tool used to record violence toward staff.

While the WVAC continued to define their role and decide on the tool to be used to record violence toward staff, the committee audited existing WRHA/HSC policies, protocols, and guidelines, specifically related to violence in the workplace. The provincial Acts which specifically address violence in the workplace were identified. Literature reviews were completed to assess programs, committees and tools used in other jurisdictions and a summary of the various assessment tools collected, were categorized for future use.

The WVAC utilized existing reporting tools to determine how the committee would identify which HSC programs/units to assess, what the assessment tool would look like, who would complete the tool, how/when the tool would be used, and how the WVAC would review the outcomes of the assessment and make recommendations. The WVAC developed a decision map to guide the selection of programs to be assessed. The I/NM forms and the Patient Safety Reports (PSR) are reviewed to identify any spikes in violence or a steady increase in violence in specific programs/units (Zichello, C. et al., 2010). Additionally, PSRs are reviewed to determine any patient related factors that could increase risks to staff. Although the quality of the data provided by the I/NM form is affected by the underutilization of the form by HSC staff, the WVAC continues to review it on a quarterly basis. However because of the concerns with the I/NM data the programs selected to be assessed are not based on this data alone rather the combined anecdotal knowledge of committee members is also considered.

A reporting format/tool was developed to summarize the completed assessment and the recommendations of the WVAC. The report including recommendations goes to Manager/Supervisor and Director of the program, Joint WS&H committee, program WS&H committee and VP/CNO. The leadership of the program reviews and prioritizes the recommendations based on operational feasibility. Recommendations are in 3 categories a) environmental, b) policies/protocols/practice guidelines, and c) staff/team. Quarterly reports are completed to meet the seventh test of compliance of the ROP (Accreditation Canada, 2010). The quarterly reports go to VP/CNO and HSC Joint WS&H committee. These reports commenced in the fourth quarter of 2010. The goal is to complete a minimum of one WVAC assessment per quarter. Response from program leadership to date has been positive.

The WVAC assessments are three pronged. The OESH team member does an assessment using the WRHA assessment tool. The security team member does an assessment from a security perspective and the other team members complete a focus group with frontline staff.(Zichello, C. et al, 2010; Registered Nurses Association of Ontario, 2009) The focus group asks the frontline (interdisciplinary) team members six questions:

1. What training do you have to prepare you for the potential of violence in the workplace?
2. What are the types of violence you have been experiencing?
3. What factors do you believe are contributing to the violence?
4. How do you cope with the violence in the workplace?

5. What supports are there for you in the workplace and are they helpful?
6. What changes or improvements do you believe would more effectively address violence in the workplace?

The focus group provides frontline staff a venue to express their knowledge, opinions and challenges related to workplace violence in their program (Kling, R. et al, 2009; Gates, D. et al, 2005; WHO, 2002). The WVAC review the two assessments and the focus group results in order to develop the recommendations for the report.

Evaluation

Following a year of assessing, planning and development, the WVAC was officially launched in November 2011. Since that time the committee continues to clarify its role within the organization as an agent of change, committed to making staff safety a priority for every HSC employee. Committee members continue to raise awareness of the issue of WPV by specifically identifying the resources and processes in place to address the issue, to groups and departments at HSC.

In January 2012, a provincial Advisory Group on Violence Prevention for Health Care Workers was developed. The mandate of this group is violence prevention in health care for the province of Manitoba. They will be looking at 1) the development of a provincial prevention policy, 2) development of risk assessment tools that will be provincially mandated, 3) developing a provincial tracking tool (which includes how the data will be captured), and 4) provincial standards for staff training.

In reviewing the Quarterly reports with the VP/CNO it is acknowledged that the data being collected from the I/NM and PSE reports continues to demonstrate under-reporting thus providing an incomplete picture of workplace violence at HSC. A decision was made to continue to use these tools for 2012 to see if increased use and exposure of the forms among leaders and staff will increase their use and potentially reflect greater consistency with the actual number of workplace violence events that are occurring. The WVAC takes every opportunity to educate employees and leadership that the I/NM forms are the accepted method of collecting workplace violence data at HSC and in the WRHA while reinforcing the importance of consistent use of the tool.

Future Directions

In May 2012, the WVAC began publishing a monthly article in the HSC monthly newsletter on various aspects of workplace violence. The articles assist HSC in meeting the eighth test of compliance for the ROP which states *"the organization provides information and training to staff on the prevention of workplace violence"* (Accreditation Canada, 2010) and is another way the HSC informs staff about the importance of preventing workplace violence. The WVAC continues to explore new ideas to support HSC in reducing workplace violence and by the end of 2012, the WVAC will complete an assessment to determine how effective the committee has been and to identify any opportunities for improvements.

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Learning objectives

1. To discuss one organizations journey to address externally driven obligations to prevent workplace violence.
2. To explore the benefit of creating systematic frameworks for encouraging a process of impartial reflection when developing and implementing change initiatives.

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Characteristics of violence experiences by Lithuanian health professionals in some medical institutions

Paper

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Focus: Practice
Keywords: Violence, health professionals, patients

Introduction

It is obvious that violence experienced by medical professionals at work is a very relevant topic, however, in Lithuania there is almost no statistical data and preventive or supportive measures concerning this issue. The following forms of violence are distinguished: Verbal abuse - A patient/client, their friend/s, family member/s, other professional/s, or work colleague/s using offensive language, yelling, or screaming with the intent of offending or frightening you. It can include threats or abuse over the phone, but excludes sexual harassment and sexual assault. Intimidation - A patient/client, their friend/s, family member/s, other professional/s, or work colleague/s purposely threatening, following you, using gestures to purposely offend or frighten you. Physical abuse - A patient/client, their friend/s, family member/s, other professional/s, or work colleague/s physically attacking you, or attempting to attack you. It includes behaviors such as punching, slapping, kicking, or using a weapon or other object with the intent of causing bodily harm. Sexual harassment - Any form of sexual propositioning or unwelcome sexual attention from a patient/client, their friend/s, family member/s, other professional/s, or work colleague/s. It includes behaviors such as humiliating or offensive jokes and remarks with sexual overtones, suggestive looks or physical gestures, inappropriate gifts or requests for inappropriate physical examinations, pressure for dates, and brushing, touching, or grabbing excluding sexual touching (e.g., the genital or breast area) [1].

In 2008 a study of stress experienced by nursing professionals worked at Vilnius University Emergency Medical Service Hospital was conducted. As many as 89% of the specialists surveyed had experienced psychological violence during the past 12 months of their work at the hospital, 65% of them had been repeatedly offended and 39% had been intimidated at work [2]. A study of similar nature was conducted in Kaunas – in 2010 stress and violence experienced at work by doctors and nurses of Emergency Unit of the Kaunas Medical University Clinics was investigated. Results were similar – subjects reported frequent experience of stress and various forms of physical and psychological violence at work [3]. Another study was conducted at Klaipėda University and assessed violence experienced by nurses caring for addiction patients. The study revealed that as many as 46% of nurses aged 20 to 25 years experienced emotional violence during the first year of their employment. It was found that verbal aggression was experienced by 80% of nurses, almost half experienced verbal offences and many others experienced derogation, bullying, and harassment [4]. According to the National Audit Organization, the number of health professionals experiencing violence is increasing every year – during the period from 1998/1999 to 2000/2001 their numbers increased by as much as 30% (NAO, 2003) [5]. Some authors (Beech, 1999), believe that health professionals experience violence four times more often than the general population. Breakwell and Coombes assert that even nightclub security staff has safer work than some of the nurses. Nine hundred deaths and 1.7 million nonfatal assaults occur each year in the United States due to workplace violence. These numbers represent only the most serious physical violent incidents; the extent to which all types of violence are experienced in the workplace remains unknown. Workplace violence is a serious concern for emergency nurses. Due to under-reporting, the occurrence of physical violence and verbal abuse toward emergency nurses remains not well understood [6].What are possible consequences for employees experiencing violence and abuse? Possible extreme outcomes include inability to work, while in less severe cases psychological help in necessary. Rippon notes that such disorders as post-traumatic stress disorder, anxiety, impaired quality of work or sleep disorders are possible. There is evidence that eventually such employees may experience lower self-confidence and reduced self-esteem (Kaye, 1996). O'Connell et al. noted a direct relationship between experienced aggression and abuse of alcohol and other drugs [5]. Is it possible to reduce the risk? The answer appears to be positive. One of such measures may include purposefully trained personnel skilled at early recognition of possible conflict situations. One relevant study was conducted in New South Wales (Australia). It included several days of intensive staff trainings how to work in aggressive environment. After the training there was a significant increase in self-confidence of the staff, as well as increase in knowledge and skills [7]. In 2006 a study of nurses was conducted in Tasmania (Australia). The study included 2407 subjects of whom as many as 63.5% had had experienced some kind of aggression (verbal or physical) within the past four weeks of work [8]. A study of Hudgson et al. conducted in 2004 in the USA covered 142 hospitals (70 000 employees) and revealed that 13% of subjects had experienced physical violence at work. Duxbury distinguishes three groups of factors, which may cause aggression or violence against employees: internal factors – mental disorders, alcohol, drugs, etc.; external factors – lack of privacy and space, overcrowded hospital wards; and interactional factors related to interaction between staff and patients [9]. A study conducted in Jamaica included 832 health professionals. As many as 38.6% of them reported having

experienced psychological violence, 12.4% reported having suffered bullying, and 7.7% experienced physical violence [10].

Purpose and objectives of the present study

The purpose of the study is to assess prevalence, characteristics, and consequences of workplace violence experienced by various kinds of medical professionals in Lithuania. To achieve this purpose, the following objectives have been defined: 1. To identify the most prevalent kinds of violence experienced by medical professionals; 2. To establish the kinds of persons, from whom violence is experienced; 3. To assess effects of violence experienced on work performance and to investigate actions of medical professionals after experienced violence.

Subjects and research methods

Subjects surveyed were health sector employees working at medical facilities of Kaunas and Šiauliai cities in Lithuania. Subjects were surveyed using a 25-item questionnaire developed by the investigators and including items concerning socio-demographic and professional data as well as characteristics of experienced violence – nature of violence, including verbal violence (offensive remarks, bullying, etc.), psychological violence (professional discrimination, derogation, calls, letters, mass media, etc.), physical violence (pushing, beating, etc.), sexual violence (remarks of sexual nature, touching, etc.), persons, who were sources of violence, actions of violence victim, and effects of violence on work performance of a victim. Statistical analysis of data was conducted suing the SPSS 16.0 software, the statistical significance level was chosen to be $p<0.05$.

Results

A total of 568 health sector employees were surveyed. Subjects included 81.5% (n=463) women and 18.5% (n=105) men. In terms of position, the sample included 32.4% (n=184) doctors, 45.1% (n=256) nurses, 18.7% (n=106) assistant staff, 1.4% (n=8) drivers, 1.6% (n=9) psychologists, 0.4% (n=2) social workers, 0.5% (n=2) others. In terms of the nature of medical services provided, subjects included 37.1% (n=211) of medical surgery staff, 28.2% (n=160) conservative medical staff, 20.4% (n=116) psychiatric staff, 8.3% (n=47) emergency medical service staff, 6% (n=34) emergency room staff. Mean age of subjects was 42.98 years (SD 11.779). Some 54.8% (n=311) of subjects reported some experience of violence, while 45.2% (n=257) reported no experience of violence. Most of the subjects reporting experience of violence indicated having experienced two or more kinds of violence, predominantly verbal and psychological violence (Figure 1). Most of subjects reported experiencing violence from patients and their relatives and much smaller number reported experiencing violence by colleagues (Figure 2). Nurses feel less secure in work environment than doctors ($p<0.05$). The numbers of subjects, who did nothing or asked for help after violent incidents was similar (Figure 3). For 53.1% (n=164) of subjects experienced violence had no consequences, 27.2% (n=84) did not ask for help, even though they had suffered from poorer well-being (insomnia, tension, bruises, etc.) after experienced violence. For 39.2% (n=21) of subjects experienced violence had some effect, 38.8% (n=20) reported no effect, and 22% (n=68) did not know whether experienced violence had any effect on further work performance.

Figure 1: Kinds of violence experienced

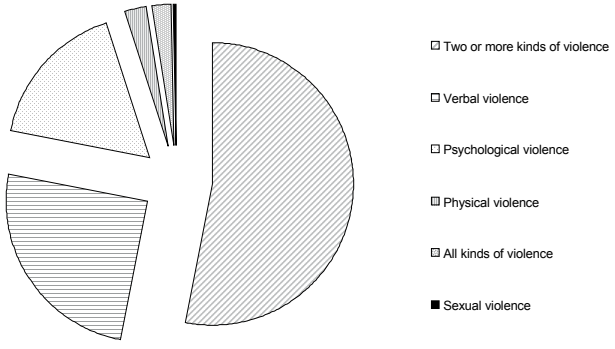
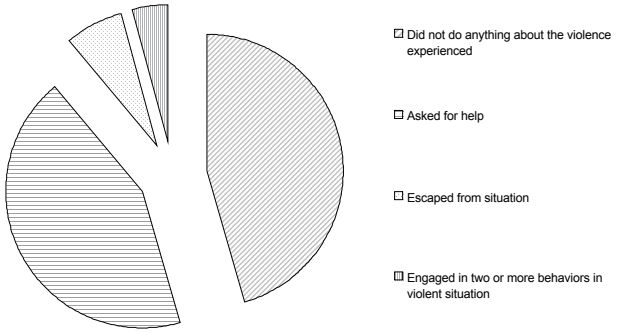


Figure 2: Persons performing violent acts

Figure 3: Subjects' actions after the violence experienced



Discussion

According to results of research conducted in Europe, some 9 percent of medical staff in the European Union had been victims of moral harassment at work [11]. The problem of violence is being discussed in literature of health professions for over 20 years, yet society still fails to make a connection between violence and hospitals. Violence, which is unjustifiable in society, is still more unacceptable in medical institutions, which receive patients with illnesses and traumas, who look for help. Still, it is recognized that violence becomes ever more prevalent in health sector around the world and even represents an international problem. It is also agreed that there is a lack of international research which would prove to the society once again the existence of the problem and would allow developing prevention programs for solution of this problem. The kind of violence, which was most often experienced by our subjects was psychological, verbal violence. Psychological workplace violence is differently defined in various cultures and various terms are used. Over 10 synonyms are used in scientific literature to define the phenomenon of psychological violence at a workplace [12]. Things, which are called psychological coercion in one country, may be considered a regular conflict in another. Manifestations of psychological violence became widely described after the Industrial Revolution, during which factories were notorious for cruel exploitation of workers. Psychological violence existed as a self-evident workplace phenomenon for a long time and only recently has become a cause of public concern and an object of scientific research [13]. In international literature it is often stated that there is a lack of common international and national conception of workplace violence. Definition of workplace violence (including psychological violence) is the first and foremost step, after which recognition of experience of violence, reporting of the event, and, eventually, systemic data collection and analysis would follow. Scientific research proved that incidence of workplace intimidation is influenced by management style used in the institution and a lack of employee's control over his/her job [14, 15, 16]. According to the literature, employees experiencing psychological violence at work believe that they are themselves to blame for all what is happening to them and that their personal characteristics are the cause of psychological violence directed against them. Employees, who experienced violence, tend to blame themselves for the incident, experience emotional distress, feel ashamed, and despise themselves [17]. Results of our survey do not reveal any tendency of those experiencing violence to seek help more often. This problem is still often hidden or a person tries to sort it out him/herself. People do not seek help even if after a violent incident their well-being deteriorated (insomnia, tension, confusion, etc.). A study of secondary school teachers conducted by Lithuanian scientists confirmed that psychological terror is conducive for cardiovascular diseases [18]. Many scientific articles describe consequences of psychological violence on mental health of employees, starting with reduced self-esteem, self-effacement, pathological fear, increased frequency of somatic

disorders, anxiety, depression, insomnia, workplace stress, and finishing with more serious cases of post-traumatic shock or post-traumatic stress syndrome [19]. Other fearsome consequences may include social isolation, conflicts in the family, and financial problems caused by absenteeism or loss of work. Most of the subjects reported that the violence experienced affected their subsequent work performance. It had been proved that psychological violence at the workplace causes reduction of work satisfaction and often becomes a reason for changing position or even employer. Reductions in work motivation and work productivity had been observed among psychological violence victims working in the healthcare sector [20]. Psychological tension at work reduces employee alertness, ability to perform their tasks in a quality and timely manner, and increases the number of faulty decisions [21]. This consequence of psychological violence is particularly important in a healthcare sector, where employees are responsible for other peoples' lives.

Recommendations

1. On the basis of results of our study we would recommend providing more information to employees about how to recognize violence and how to act in such situations.
2. As most of the violence comes from patients, staff should be trained how to recognize and avoid it and how to handle aggressive patients. It would be useful to prepare a list of sources of psychological help for those likely to experience violence. It is also recommended that healthcare institutions should have psychologists, who would be able to provide anonymous help to healthcare staff.
3. To avoid negative consequences of violence, it is necessary to ensure competent, rapid, and objective investigation of incidents of violence involving employees.

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Learning objectives

1. Important interfaces were not established while analyzing the frequency of nurses' actions, which had been applied in the face with an aggressive patient over the past year, depending on nurses age and their training.
2. Violence against the nurses in mental hospital is a serious problem.

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Reducing the risk in healthcare: An integrative and systemic approach

Workshop

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Focus: Education and Training
Keywords: violence prevention, healthcare, hospitals, team intervention, team response, code white, risk reduction, Advanced Response Training, personal safety

Abstract

In 2007 the Interior Health authority, which covers approximately 355,000 square kilometers in the province of British Columbia located in Canada, embarked on developing a Violence Prevention Program. This included staff education and training and other related infrastructure components needed to support and sustain the program. In partnership with an external provider, Advanced Response Training, Interior Health was able to collaboratively develop a healthcare specific program tailored to support and sustain an emergency response team in each of the regional/tertiary acute care facilities. The emergency team response has provided a tool for healthcare employees to utilize when presented with violence in the workplace. Discussed will be the process of the response team, the training, education, infrastructure and outcomes of this program.

Results will identify statistical gathering, documentation records, collation and analysis of data; followed by the outcomes reported from the largest three tertiary/regional sites within Interior Health. Of statistical significance will be the risk/cost reduction that has been demonstrated post implementation of this healthcare specific violence prevention program. Additional factors have also contributed to this risk/cost reduction. The data supports that there is a direct correlation between specific violence prevention education and infrastructure and cost avoidance/injury reduction. The results indicate that beyond the empirical data there has been a paradigm shift in culture to one of respect and safety amongst the staff, external security providers and patients. Further, this will be supported with post training feedback at 6 months and 1 year.

Introduction and background

The people who make up an organization are its most important asset. People spend years, and some at great expense, completing their chosen field of education which allows them to be productive and valued employees for organizations. In some instances, these valued employees have, unfortunately, experienced violence within their workplace.
Even though many healthcare organizations provide violence prevention education at new hire orientation thereby increasing knowledge of policies and procedures workers are still getting injured in the workplace at ever increasing numbers. This is supported by WorkSafe BC data from 2000 which states that approximately 40 percent of all violence related claims in British Columbia come from health care employees contrasted against the statistic that health care employees are only 5 percent of the provincial workforce {1}.

In the spectrum of training, whether it is basic knowledge, orientation of new employees or specific as in new technology, systems, policies or as in this case safety, the methods and the trainers used to transfer that knowledge are paramount to obtaining an acceptable level of success.
The primary goal of the Personal Safety and Code White violence prevention training being discussed is to reduce the risks of injuries to employees. Utilizing empirical data from pre and post implementation, the Interior Health Authority has reported that there was an approximate 48 percent decrease in injury loss for the fiscal year following the first year of implementation (2009-10) {2}.

Another useful measurement of success is to reflect upon the behavioural change reported by employees post training. This feedback provided a window into the application and retention of knowledge.

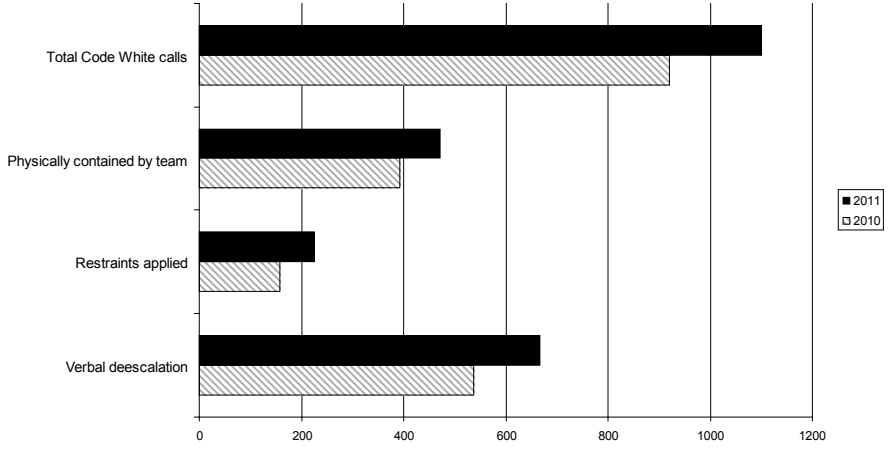
Training initiatives can be impacted by various factors. A resistance to change along with different training modalities and a lack of ownership are some of the issues encountered in many of the sites chosen for this training. These were only a few of the considerations that we accepted. By utilizing inclusion, flexibility, dignity and understanding of the various aspects and needs of each department within the organizational structure we began to see success. The success of this training has come from the integrated approach of using and developing internal support combined with on going external facilitation.

Curriculum

This program promotes a paradigm shift away from patient safety to a more balanced and centered approach which combines both staff safety with safety needs of patients in healthcare. Health care providers must ensure that their own health and wellness is paramount because without nurses, doctors, care aides, porters etc. there would be no one able to provide the necessary care to our patients.

This curriculum includes a basic understanding of the rights of all individuals as provided under the Criminal Code of Canada and the application of these laws within the workplace. An emphasis on recognizing early warning signs and behaviours is key to being able to intervene early and often a skill that is invaluable in reducing risk. Early detection and intervention provides staff with an opportunity to provide an appropriate level of intervention that in most cases does not require physical contact.
This early detention is highlighted in the graphs below where we can quantify that the more interventions that are managed by verbal de-escalation leads to a decrease in risk to all involved. to quantify this risk reduction.

Figure 1: All hands off incidents 2010 and 2011



Of the 921 team interventions recorded, (in 2010 for Interior Health) 537 interventions were handled using only verbal de-escalation techniques. This equates to a 58% reduction in risk to the staff involved. Of the 1,101 team interventions recorded (in 2011 for Interior Health) 666 were handled using only verbal de-escalation techniques. This equates to a 61% reduction in risk to the staff involved.

This healthcare specific training is tailored to meet the needs of the participating employees based upon their level of risk, ability to respond and access to tools (i.e. seclusion room, mechanical restraints). This follows the Interior Health emergency response levels. {3} This training platform meets the needs of a multitude of health care facilities, from the basic personal safety education about what staff can do to keep themselves safe, to a full 3-5 person team approach to dealing with an aggressive individual in facilities that have the tools and resources to support this highly skilled team. It can be modified to fit a response plan for all sites and meets the criteria of Occupational health and Safety regulations around providing violence prevention education to all staff.

Tailoring the training to meet each of the levels of risk is key in not only becoming successful, as previously stated, but in making it tangible and applicable for all health care workers. By utilizing their vernacular when delivering the training and employing examples that are directly related to their work settings workers can assimilate the training into their day to day tasks. Providing flexibility in the delivery of the content to allow each participant to 'buy into" and support the curriculum as something that is not only applicable but also useable. The training process also emphasizes the inclusion of line supervisors and managers participating and promoting the application of the training. This level of understanding and support allows for an easier transition process and a faster cultural shift.

In the following table, we have included staff perceptions taken at the end of a training session. This is a comparative sampling of all staff trained and is taken from Personal Safety and Team Intervention classes.

Personal Safety and Team Intervention Classroom Survey

Answer Options	Excellent	Very Good	Good	Fair	Neutral	Poor	Response Count
The training was relevant to your position	129	48	13	1	2	0	193
Your confidence has been increased by this training	113	61	16	1	0	0	191
Your ability to safely assess behaviour has been increased	106	69	13	0	0	0	188
Answered Question							194

Key Infrastructure Support

A key infrastructure component of creating a sustainable Violence Prevention training program is identifying site champions /instructors. Fiscal responsibility, vast geographical distances and staff availability are obstacles that have played into this sustainability plan. Unlike other violence prevention education programs which can include purely e-learning or train-the-trainer models, we have developed a hybrid approach of using both e-learning , classroom and instructor development/ mentorship. Typically, the initial participation in the classroom sessions allows the opportunity for the Master level Instructor (ART) to observe for potential instructors. With this information a collaborative approach of communicating with the management and health and safety department will determine if a chosen individual will be supported through the instructor development process.

These selected individuals need to not only have a good grasp of the programs philosophy and an above average physical technique skill set but also possess an approachable and engaging personality. Progression to higher levels of facilitation is met through specific developed criteria and is supported through continuous mentorship and individually developed support plans. A key difference from the 'train the trainer model' is the individual ability to meet the learning objectives will dictate progression regardless of number of sessions/ workshops attended {5}.

Interior Health participated in a provincially led initiative (Health and Safety In Action #4) {6} focusing on violence prevention education components. One of the findings from this initiative was that instructor development should focus on establishing criteria around instructor requirements and that evaluations of learning objectives was key to maintaining a consistent level of instruction. This unique process has shown success in building strong instructors and champions of violence prevention.

Outcomes

A way to measure the success of a safety training program is to analyze the outcomes of a training program through post education evaluations. Using an online survey option, sent to all staff that have had training in the Health Authority, we summarized a small sampling. The sampling was taken from all class types and job classifications.

Personal Safety and Team Intervention Post Training Survey

Answer Options	Excellent	Very Good	Good	Fair	Neutral	Poor	Response Count
The training was relevant to your position	14	17	9	5	3	0	48
Your confidence has been increased by this training	9	15	14	8	0	2	48
Your ability to safely assess behaviour has been increased	8	19	13	4	3	1	48
Answered question							48

An additional outcome from this training program has been the ability of staff to apply areas of this training into their personal lives. On many occasions, participants have returned to report real life stories where through the utilization of this training they have prevented injuries from occurring in their personal lives. Therefore not only does the training have an impact on employee safety while off the job but it can have the additional benefit of reducing the effect of time loss from non-work related injury while creating that *"buy in"* that is key to changing a culture in a work environment.

Summary

The on-going relationship with Interior Health, Northern Health, Workplace Health & Safety, WorkSafe BC and Advanced Response Training, has provided an exceptional opportunity for collaboration, development and growth in the reduction of risk and injury to people as a result of violence. Training is but one aspect of a successful violence prevention program but lays an integral foundation from which the remaining aspects can be built upon. The teamwork, openness, recognition and response to the safety concerns of staff has contributed to the training program successes to date. The ability to be flexible with the needs of all health care workers and environments has shown to be moving that pendulum in the right direction towards a culture of health and safety for all who enter the healthcare system.

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Learning objectives

1. The education and training success is derived from a collaborative effort including all internal and external partners creating a health care specific platform that applies to all sectors of the health care industry. The education and training components are integral to the success of this program. That said, these components will require overall infrastructure support ensuring ongoing sustainability efforts.
2. The success of this program requires dedicated support from the organization, including an identified leadership infrastructure within all levels of the organization.

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Predictive validity of HCR-20 among heterogeneous groups of secure psychiatric inpatients: Results of an audit

Paper

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Focus: Practice

Introduction

Accurate violence risk assessment is a crucial task for mental health professionals working in secure/forensic settings because it informs numerous decisions about monitoring, supervision, treatment, discharge and victim safety planning (Douglas, Webster, Hart, Eaves, & Ogloff, 2001). Errors in risk assessment have serious consequences. False positives may result in unnecessary involuntary commitment and treatment; whilst false negatives may result in harm to the individual, their families, mental health professionals and the general public (Skeem, Schubert, Stowman, Beeson, Mulvey, Gardner, & Lidz, 2005). The most widely used structured clinical judgement tool in English medium secure mental health units (used in 79% of all units) is currently the Historical Clinical and Risk Management scheme (HCR-20; Khiroya, Weaver, & Maden, 2009; Webster, Douglas, Eaves, & Hart, 1997; Webster, Eaves, Douglas, & Wintrup, 1995).

The HCR-20 is a structured guide for professionals assessing the risk for institutional and community violence in people with mental and personality disorders (Douglas, et al., 2001). The Historical (H) scale comprises ten items that are thought to be relatively static, and reflect the individual's psychosocial adjustment and history of violence. The Clinical (C) scale includes five dynamic risk factors reflecting the individual's current or recent mental health-related functioning and the Risk Management (R) scale includes five dynamic risk factors that reflect professional opinions regarding the individual's ability to adjust to the institution or community (Douglas, et al., 2001). In research settings, the HCR-20 is often used as an actuarial instrument, by summing the presence of risk factors to yield a total score.

Research comparing the efficacy of risk assessment tools for predicting inpatient aggression has produced promising results for the HCR-20, with a recent meta-analytic comparison of six risk assessment tools finding the largest mean effect size for the prediction of institutional violence was for the HCR-20 (Campbell, French, & Gendreau, 2009). It has consistently been found that the dynamic C and R scales are stronger predictors of inpatient aggression than the relatively static H scale It is likely that this reflects that the majority of studies have been conducted with forensic psychiatric patients or prisoners who, by nature of their high risk status will have high H subscale scores (Belfrage, Fransson, & Strand, 2000). However, there is evidence to suggest that the HCR-20 is not equally predictive for inpatient aggression across a range of demographic and clinical factors including gender (de Vogel and de Ruiter 2005; Nicholls 2004; Nicholls, Ogloff et al. 2004), ethnicity ((Singh, Grann, & Fazel, 2011), age (Singh, Grann et al (2011), and diagnosis (Gray, Taylor et al. 2011).

Increasing our knowledge of the ways in which the HCR-20 items interact with wider clinical and demographic categories among secure inpatients holds potential to increase the accuracy of such risk assessments. Previous studies have been limited by sample size, and study designs which have failed to collect a full range of diagnostic, demographic and clinically relevant information, due in part to their conduct as service evaluations with little individual patient data.

Method

Setting and participants

The study is part of an ongoing study with male and female inpatients at St Andrew's Healthcare, a large charitable provider of mental health care in conditions of medium and low security for men, women and adolescents with mental illness and learning disability.

Procedure

Data was collected as part of a charity wide audit of HCR-20 risk assessment completion. All of the information collected was routinely gathered and/or recorded in patients' records as part of St. Andrew's Healthcare's risk management policy. Demographic (gender, age and race) and clinical (diagnoses, legal status and admission/discharge date) information for patients; along with their HCR-20 risk assessment scores, was provided in an anonymised format by a member of their multidisciplinary team. Data regarding incidents of verbal aggression, and physical aggression was extracted from progress notes for the 1 month period following the HCR-20 risk assessment. For incidents containing multiple types of aggression, only the most serious form of behaviour was recorded, with physical aggression considered the most severe, and verbal aggression the least. Psychopathy (H7) was omitted as the majority of [patients had not been assessed using the PCL-R, and hence this item could not be reliably scored. HCR-20 risk assessments with missing items were prorated according to the instructions

in the manual. Accordingly, data for patients with more than two Historical items, or 1 Clinical or Risk management item missing was omitted.

Results

Data was obtained for 207 patients, of which 12 were subsequently excluded due to large amounts of missing data. During the 1 month following the HCR-20 risk assessments, 68 (34.9%) had demonstrated physical aggression and 78 (40%) had demonstrated verbal aggression. The total number of incidents aggression recorded was 439; 222 incidents of physical aggression and 217 of verbal aggression.

Predictive efficacy of the HCR-20
The Clinical scale significantly predicted both physical and verbal aggression occurring in the one month following assessment. The HCR-20 total and the Risk Management scale were also significantly predictive of verbal aggression; whilst, the Historical scale was not predictive of either types of aggression (see Table 1).

Table 1: Predictive accuracy of HCR-20 risk assessment for inpatient aggression during the follow up period

	Physical Aggression		Verbal Aggression	
	AUC (SE)	95% CI	AUC (SE)	95% CI
HCR-20 Total	.574 (.043)	.489-.658	.618** (.041)	.538-.698
H10	.473 (.043)	.389-.557	.505 (.042)	.422-.587
C5	.633** (.041)	.553-.712	.597* (.042)	.515-.678
R5	.574 (.043)	.489-.658	.611** (.041)	.531-.690

**p<.05, **p<.01, ***p<.001*

Discussion

This study investigated the predictive efficacy of the HCR-20 for inpatient aggression occurring in the subsequent month. With the exception of the clinical scale, the HCR-20 was a stronger predictor of verbal aggression than physical aggression. It is possible that this stems from differences in risk management strategies, with more stringent management of physical aggression due to its potential for more severe consequences. In line with previous research (e.g. Chu, Thomas, Ogloff, & Daffern, 2011; Langton, Hogue, & Daffern, 2009), the Historical scale was not a significant predictor of either type of aggression.

Limitations

The principle limitation of this study was the restricted information available regarding the severity and nature of the aggressive incidents. The category of physical aggression does not distinguish between acts where an object, or another person, was the target of aggression. Further, there was no indication of the severity of aggressive acts. It would be beneficial to determine whether the HCR-20 can predict not only those who will, or will not, be aggressive; but whether it can distinguish those who are likely to perpetrate the most serious forms of aggression against others.

Future directions

In conclusion, this study provides further evidence regarding the predictive validity of the dynamic HCR-20 scales for inpatient aggression and extends this finding to a more heterogeneous population than the typically Caucasian Male samples used in previous studies. However, it is important to extend this analysis to examine how the HCR-20's efficacy varies according to a range of demographic and clinical factors; namely diagnosis, age, gender and ethnicity. Preliminary results of such analyses will be presented at the conference.

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Learning objectives

1. Participants will appreciate that it is unlikely that different clinical and demographic groups have similar risk factors for violence and aggression.
2. HCR-20 profiles over time to be presented to show the naturalistic course of risk in an institutional setting.

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Violence toward emergency department nurses: Prevalence and perception

Paper

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Focus: Research
Keywords: Emergency nurses, workplace violence, Iran

Abstract

Workplace violence (WPV) has been a serious concern for emergency nurses and emergency department (ED) is one of the most dangerous work settings in health care for nurses. Patients, their relatives and visitors were addressed as perpetrator toward ED nurses. According to the international studies, the incidence WPV toward ED nurses is not well understood because of under-reporting. This terrible destructive phenomenon has many negative effects on employer, employee, institute and clients. In Iran, there are not ED specialist nurses and so public nurses without any additional training were employed in this setting. There is not any previous study regarding this topic in Iran. Therefore, to investigate the actual extent of violence toward nurses working in ED, understanding their experiences and perceptions of violence, this study was carried.

Materials and methods

A cross-sectional study was carried out using consensus sampling of 196 bachelors degree nurses working in 11 EDs of teaching hospitals in Tehran, Iran. The data were collected through the adapted version of a self-administered questionnaire developed by ILO,WHO,ICN,PSI on WPV in the health sector. After completing quantitative section , the qualitative section was started with ED nurses that have experience of WPV. Interviews with 11 ED nurses were audio-taped and transcribed verbatim. A modified form of constant comparative analysis was used to analyze the data.

Results

The participants were mostly (89.1%) female and their work experiences (63.2%) in nursing were between 1 and 5 years. Nurses experienced of verbal and physical violence during the past year were (19.7%, 91.6%). Patients relatives were the most common sources of violence.

In qualitative content analysis section, three terms such as, innocence and vulnerability, incapacity and disability, condemnation and destruction with 10 categories and 12 subcategories were obtained.

Conclusion

Nurses working in ED have many encounters with violent patients and family members. They are affected psychologically when assaulted by patients or their relatives. The exact prevalence is not clear and they believed that hospital manager would not actively support them after report. ED nurses stated that their work environment, individual skills, hospital staffing patterns and policy for admitting patients when unable to safely care for them play important roles in the risk off violence. These nurses reported that steps could be taken to improve their safety in the ED.

Learning objectives

1. To demonstrate ideas leading to a health care setting without violence.

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A possible role for n-3/n-6 polyunsaturated fatty acids in the reduction of impulsive aggressive behavior within psychiatry

Poster

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Focus: Research

Abstract

This article researches a potential role of poly-unsaturated fatty acids (PUFA) in reducing or possibly preventing aggression in patients with psychotic disorder. Especially docosahexaenoic acid (DHA) and eicosapentaenoic acid (EPA) of the w-3 series and arachidonic acid (AA) of the w-6 variant seem to be relevant to the subject. The data presented in this paper were gathered from 194 patients with psychotic disorder participating in the GROUP-research project (www.group-project.nl) in Amsterdam. Blood samples were gathered and analyzed by means of capillary gas-chromatography to measure PUFA concentration in erythrocyte membrane. PANSS item G14 (poor impulse control) was used as a measure for aggression. Statistical analysis was done by means of Multiple Regression in Stata. Results remain inconclusive, likely to type II error, caused by low incidence of aggression and average to low concentration of PUFA (as compared to the general public) within this population.

Dietary intake and other confounding factors like gender, anti-psychotic medication, physical activity, alcohol, drugs and smoking were not taken into account in this study. Further research is needed, either by means of comparative analysis or by a trial research design.

Learning objectives

Participants will gain an understanding that:
1. Research, although not conclusive, seems to indicate that a possible association exists between concentration of polyunstaturated fatty acids and impulsive aggressive behavior.
2. Fatty acids composition could play a role in reducing impulsive aggressive behavior.
3. Supplementation of fatty acids may be able to contribute in reducing impulsive aggressive behavior.
4. A comparative analysis between a non-aggressive population and a population displaying impulsive aggressive behavior might be able to give more conclusive evidence on the subject.

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Prevention of occupational violence in out-of-hours primary care centres in Norway: A cross-sectional study

Paper

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Focus: Research
Keywords: Workplace violence, out-of hours primary care centre, safety, prevention

Introduction

Although threats and violence against health care workers in out-of-hours (OOH) primary care are frequently occurring events, there are few measures taken to prevent such incidents from happening again. Workplace violence is defined as *"incidents where an employee is abused, sexually harassed, or assaulted in circumstances relating to their work, involving an explicit or implicit challenge to their safety, well-being or health"* (1). A UK study by Kmietowic (2) reports that 1/3 of the physicians is attacked each year and that few of these have been given any aggression preventive training. A Canadian study (3) among physicians also reports a low level of awareness of institutional policies they could draw upon when they had been exposed to abuse from patients or their relatives.

The Norwegian OOH primary care service is usually managed by the regular general practitioners' clinics during office hours and by municipality-maintained OOH duties by general practitioners (GPs) during evenings, nights and weekends, often based in local casualty clinics with nursing professionals on duty (4).

A recent study reported that the prevalence of workplace violence in Norwegian OOH primary care centres is high and that one out of three employees has been physical abused during their OOH career (5). Despite this high risk for workplace violence at OOH primary care centres, there has been little focus on prevention. There is little information available regarding preventive measures applied in the centres and a basic knowledge of existing safety measures is a necessary prerequisite for further improvement of preventive practices. The aim of this study was to investigate the preventive measures of workplace violence among workers in OOH primary care in Norway.

Methods

This study was performed as part of a larger questionnaire study about workplace violence. A self-administered postal questionnaire was sent to all nurses, physicians and other personnel with patient contact in 20 of 220 OOH primary care centres in Norway in 2009. The centres were chosen in an attempt to obtain a representative sample with respect to population size, urban and rural location, and geography. Power analysis based on an estimate that 30% of the persons had experienced violence, showed that a total of 482 participants would give a 95% CI of 0.26 – 0.34 with 80% power. All study-potential OOH primary care centres were invited by phone to participate. The study included all personnel with patient contact during the study period of three weeks (January – February 2009).

All eligible participants received the information letter and questionnaire through their local leaders. After completion, the anonymously answered questionnaire was returned to the National Centre for Emergency Primary Health Care. The questionnaire included three questions aimed at education and training in aggression prevention. The participants were also asked to report aggression preventive intervention at their workplace. The questionnaire included a list of 11 possible safety measures available at the OOH primary care centre based on recommendation from the Norwegian Association of General Practitioners (6).

Demographic data included gender, age, occupation, and number of years working in OOH primary care. Analyses were performed using SPSS 16.0. Continuous data are presented as mean with standard deviation (SD). Categorical variables were analysed using chi-square. P-values < 0.05 were considered statistically significant. The study was approved by the Norwegian Social Science Data Services.

Results

From the involved OOH primary care centres a total of 536 responders (75% response rate) took part in the study. In the study 70% of the respondents were women. 35% of the respondents were physicians and 62% were nurses. Other personnel (nurse aides, medical secretaries) accounted for 3%. The mean age of the respondents was 42 years (SD 11, range 21 – 75 years).

Education and training

296 (55%) of the participants reported that they had never participated in any education in respect to aggression prevention. 145 (27%) of the participants reported participation in aggression prevention at the OOH primary care centre, 8% had received education during their initial professional training, 6% had received education during specialized professional education, while 8% had participated in such elsewhere. Twelve per cent of the participants answered that they had participated in training due to prior exposure to violence at the workplace or other personal experiences. 73% of the participants answered that they would benefit from more education about or training in aggression prevention, significantly more nurses than physicians ($p< 0.005$).

Safety measures

On each of the following items, more than 90% reported that they had the actual measure: Barrier between the reception and waiting room, view to the entrance, and view to the waiting room. The most frequently applied measure was a barrier or glass partition between the reception and the waiting room, reported by 508 (95%) of the respondents.

While 74 % of the respondents reported that their OOH primary care centre had access to alarm systems, 64% reported that they had close-circuit television camera (CCTV camera).

Only 31% reported that they had established routines in respect to prevent threats and violence. 49% of the participants reported that they had an alternative exit door from the physician's office, and 18% had arranged the office in such order that the patient was not seated between the physician and the exit. 16 % of the respondents worked in a centre where a security guard was available.

Discussion

This study's strength is the high response rate. The results are therefore most likely representative for Norwegian OOH primary care centres. The participating centres represented different sizes and geography. The distribution of nurses and physicians is supposed to reflect the workers at the centres.

More than half of the participants had never received any training in aggression prevention at all. Very few, only 31% of the participants, reported that aggression preventive interventions where at place at their centre, even if the Norwegian Medical Association has had a designated campaign towards the topic of workplace violence. The lack of organized and structured training aimed at aggression prevention could be explained by lack of a national policy. Other countries such as Australia and the United Kingdom have a national policy that assists physicians to protect themselves against violent patients (7- 8). The finding that as much as 74% of the participants reported that they would benefit from more training in aggression prevention, supports the perception that there is a need for a more systematic education on this issue among employees in OOH primary care.

Almost all employees reported that the physical environment in the reception area was in line with recommendations about barrier between reception and waiting room as well as view to the waiting room and the entrance. More than half of the participants also reported that they had alarm or CCTV camera at the centre. On the other hand, only 18% reported that the consultation room was arranged to avoid the patient sitting between the physician and the exit, as recommended by Norwegian Association of General Practitioners (6). The low percentage of implementation highlights that the consultation room has a large potential for safety improvements, most likely through minor changes.

Conclusion

The employer should take action to prevent workplace violence in OOH primary care.
The need for training in aggression prevention should be especially focused upon. This knowledge about preventive measures of workplace violence among workers in OOH primary care is important for the further discussion of what is needed for prevention of workplace violence.

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Learning objectives

1. This is the first study of preventive measures in out-of-hours (OOH) primary care centres in Norway.
2. The knowledge of existing preventive measures in OOH primary care centres is important for the further discussion of prevention of occupational violence.

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Management of violence in nursing: Challenges and opportunities for developing countries

Paper

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Focus: Guidance

Introduction and context

The paper is based on conclusions from survey studies in two large cities in sub-Saharan Africa, i.e. Cape Town in South Africa (2008) and Kumasi in Ghana (2011). The context was to investigate extent that violence exists in the nursing profession at nurse-nurse and nurse-patient interactions. Sturruck (2012) proposed that assessment of violence should also include assessment of nurses' attitude, experience and the clinical environment. Whatever, approaches utilised, some health care consumers and minority of nurses would always resort to violation of people around them in the workplace. Steinman (2007) proposed varieties of ways to manage bullying and violence in the workplace. In addition, Khalil (2009a) proposed strategies to prevent violence against midwives in Cape Town, South Africa.

Some reasons for the violence in nursing

Causes of violence between nurses and health care consumers were similar in the two cities of the study. Primary contributory causes of verbal aggression against nurses were attributed to long waiting periods and apparent lack of resources to address needs of patients (Khalil 2009a; Roche et al 2011). The second causes were attributed to uncompassionate attitude of some nurses towards patients and patients' relatives. Perpetrators of violence: findings from the two studies indicated that patients' relatives were the main perpetrators of violence (Khalil 2009a; Pinar and Ucmak 2011) whilst other health care professionals were identified to have resorted to similar modes of behaviour when frustrated. Effects of violence on nurses and health consumers: nurses reported sleep disturbances after violent incidences at work (Khalil 2010; Pinar and Ucmak 2011), whilst essential nursing interventions were withheld for abusive patients. On rare situations, some nurses were reported to have resorted to physically abusing patients.

Challenges for managing violence in nursing

Chronic shortage of qualified nurses which had been compounded with significant exodus from the profession meant that patients were left unattended for long periods (Roche et. al. 2011). The growing awareness of the public about their rights to health care had raised their expectations of nursing services despite the shortage of qualified staff. Nursing programmes in the two cities had not prepared nurses to deal with violence directed against them. On the other hand, there is no evidence that patients, patients' relatives, and other health care professionals that violate nurses were ever prosecuted. Nursing in these two large cities is still sub-servant to the medical profession although the South African nursing profession is more assertive than its Ghanaian counterpart. Nursing population in the two research sites were reluctant to adequately complete questionnaires, therefore it was difficult to explore extent of violence exist in the profession.

Opportunities to address violence in nursing

Employers of nurses must provide continuous professional development programmes including assertive training (Khalil 2008 and 2009; Embree and White 2010). Some respondents indicated that unit managers had actively discouraged them from pursing further professional development because of staff shortages (Lanza, et al. 2011). Such comments whether true or not, demoralise nurses. In addition, posters information health care consumers that they would be prosecuted if they attach hospital staff would serve as a deterrent. Furthermore, exist interviews of patients must be conducted as an integral part of discharge care planning in all health care facilities to determine quality of nursing care received. In addition, health care consumers must be empowered to lodge complaints about poor nursing care and there should be transparency during investigations of such complaints. Concerted efforts must be made by hospitals and clinics' Directors of Nursing to monitor nurses' performance in their respective institutions (Hutchinson, et al 2010). Regular nursing audit of all health facilities would highlight areas for improvement. University nursing departments and colleges of nursing should counsel students that do not show interest in clinical practice to seek alternative career path. Finally, concerted efforts must be made to weed out 'bad apples' from the profession. A 'bad nurse' is a danger to patients, the country, Africa, and the profession.

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Learning objectives

1. To demonstrate extent that violence exists during nurse-nurse and nurse-patient interactions.
2. To outline values of continuous professional development for nurses working in low-resource institutions to manage workplace violence.
3. To demonstrate potential benefits of nursing audits as tools for detecting and minimising workplace violence in developing countries.

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Implementing a community risk screen tool

Paper

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Focus: Practice
Keywords: Risk assessment, staff safety, stakeholder engagement

Introduction

What if you provided care to a person in their home who lived with a relative who was volatile and unpleasant? What if your job included walking down a dark street from your car to the icy, unlit stairs of a client's home? Would you consider these to be on-the-job risks? Would you think these risks were acceptable? Home and Community Care workers face many safety risks and are injured in the course of their work (e.g. workplace violence, ergonomic risks). In British Columbia, Canada, it is estimated that every year over 900 Home and Community Care workers sustain injuries requiring time-loss compensation which amounts to over $4.8 million in claim costs and over 35,500 days of work lost (WorkSafeBC, 2009). In Vancouver Coastal Health Authority there are approximately 3,000 Community workers.

Early in 2009, a need to develop a comprehensive, standardized risk assessment process for all community care programs was identified by senior executive directors for Vancouver Coastal Health Authority (VCH) as each region varied in their approach to determining risks to staff.

A consistent risk assessment process would enable staff to:
- Identify potential risks to their health and safety e.g. clients that have a history of violence or substance abuse, potential for overexertion or strain from client handling.
- Develop risk reduction and avoidance strategies
- Communicate risks with others
- Provide better quality patient care.

A standardized risk assessment process would ensure organizational compliance with provincial regulation which requires the completion of a risk assessment for all work environments where workers may be exposed to occupational hazards. It would also ensure that VCH would meet Accreditation Canada's Required Organizational Practices for *"Home Safety Risk Assessment"*.

Ultimately, the creation of a risk assessment process for the Community sector would improve communication of risk across the Health Authority and between all community programs, and reduce staff exposure to risk and injury.

Methods

The development of a standardized risk assessment tool began in September 2009 with the acquisition of project funding and the creation of a project charter which identified the project goal, objectives, plan, stakeholder groups, budget, and roles and responsibilities. The project components consisted of: the development of a Community Risk Screen (CRS) Tool; the creation of an organizational policy to support the CRS Tool; pilots to evaluate the CRS Tool; education sessions to roll-out the final CRS Tool to all community workers; and, a sustainability plan.

All CRS Tool project activities were coordinated by a Project Manager. In addition, several stakeholder groups, including community staff from all regions and programs, were created to oversee and assist in the development of a CRS Tool including:
- A **Steering Committee** which led and supported the project. The Steering Committee consisted of community program directors and regional managers.
- A **Resource Group** which provided support and advice to the Working Group and project. The Resource Group consisted of managers and practice leads.
- A **Working Group** which supported the project, developed the CRS Tool and process, and worked with pilot groups. The Working Group consisted of managers, educators, team leaders, clinical coordinators and front line staff. The Steering Committee and Working Group met regularly and communicated with all managers, employees and Joint Health and Safety Committees on an ongoing basis.
- **Pilot Groups** which tested the CRS Tool and provided feedback to the project groups. The Pilot Groups consisted of teams of frontline staff from various community programs.
- A **PARIS e-Committee**. PARIS is the Primary Access Regional Information System which is used by many community programs within VCH. The PARIS e-Committee provided input on the creation of an electronic CRS Tool module for the existing electronic information system. The PARIS e-Committee consisted of members from the Working Group, Information Management/Technology Services (IMTS), intake workers, and educators.

- User Testing Group which consisted of front line staff, educators and managers from all community programs who tested the electronic module.

Community Risk Screen Tool
The development of a CRS Tool began November 2009. The CRS Tool development process consisted of gathering and reviewing VCH and external risk screening tools to identify knowledge gaps and best practice.

A paper version of the CRS Tool was completed in November 2010 followed by an electronic version in September 2011. Paper and electronic versions of the CRS Tool were available to ensure that sites that do not have access to PARIS are able to conduct a risk assessment.
Several support documents were developed to assist with the implementation and application of the CRS Tool.

Community Risk Screening Policy
A Community Risk Screening Policy was developed to support and sustain the CRS Tool. Input in the policy development was provided by key groups and users (e.g. directors, managers, Health Authority interprovincial advisory councils, privacy, communications, risk management, quality and patient safety). The policy was completed and approved by October 2011.

Community Risk Screen Tool Pilots
A paper format of the CRS Tool was piloted, user tested, and evaluated. Six sites representing all community programs and regions involving 200 participants took part in the pilot from June 15 to August 6, 2010. The pilot considered: adequacy of training; ease of use; length of time it took to complete the risk screen which included an appropriate number of hazards listed; meeting stakeholders' needs; and content of support documents.

The electronic CRS Tool module was tested by users in August 2011; all identified technical user issues were corrected before CRS Tool implementation.

A post evaluation survey took place in July 2012 for all community workers to identify whether the objectives for the CRS Tool were met. Objectives included: identifying risks and increasing awareness and reduction of same; focusing on staff safety; providing appropriate education; improving communication; and, developing a tool that is practical, reliable, easy to use. Results of the post evaluation survey will be available September 2012.

Community Risk Screen Tool Implementation
The implementation of the CRS Tool in all community programs took place in September 2011. Educators were trained using the *"Train the Trainer"* model. Seventy-five designated educators representing all regions, programs and most teams attended CRS Tool training sessions.
The electronic CRS Tool module went live November 2011.

Results

A CRS Tool was created for VCH Community that is practical, accessible, reliable, effective, user-friendly and sustainable. The CRS Tool is also applicable to all community programs and respects client confidentiality.

During the risk screening process, all clients are assessed for environmental hazards e.g. site location, presence of pets/animals; uneven flooring/stairs, unsafe equipment; musculoskeletal injury hazards e.g. client with limited mobility and requires assistance with transfers/repositioning; violence/social hazards e.g. history of violence and/or abuse, presence of weapons, client with poor judgement and insight; and health hazards e.g. bed bug infestation, infectious/communicable disease.

The CRS Tool consists of the following components:
- A Pre-Visit Risk Screen – A Pre-Visit Screen must be conducted prior to the initial visit with the client. Information is gathered over the phone, from the client's records, the client and client's family/friends/caregiver(s). A Risk Control Plan must be developed for all identified risks. All risks and interventions must be documented and communicated to all staff via program specific methods (e.g. PARIS).
- An Initial Visit Screen – The Initial Visit Screen is performed prior to full service provision to determine if service can be provided immediately or if alternate arrangements need to be made until all controls are put in place. The purpose of the screen is to identify, document, mitigate and communicate any new risks.
- A Review Visit Screen – The purpose of a Review Visit Screen is to identify, document, mitigate and communicate any new risks that may have developed. Reviews are required annually, when there is a change in the client or worksite, or after a staff injury. All high risk situations must be continuously evaluated.
- A Risk Control Plan – A Risk Control Plan is a course of action that assists with the elimination or reduction of risk to staff. It must be completed as soon as a risk is identified and is communicated through program specific methods (e.g. PARIS).
- Alert – A Staff Safety Alert is created when a risk is identified and is left in place as long as a risk remains evident and is being managed by the Risk Control Plan. There may be multiple Alerts on a client's record in PARIS e.g. A client may have an alert for "Suicide Risk" and an alert for violence because they have a history of substance abuse and recent incidents of aggression towards staff.

The following support documents were developed and made available on the VCH intranet including:
- Instructions for Use (for the paper format) and Practice Guidelines (for the electronic format in PARIS) on how to use the CRS Tool.
- A Reference Guide to help workers identify risks and safety strategies to consider for a variety of hazards.
- A Script for the CRS Tool to assist workers in applying the CRS Tool during calls with clients.
- A Tip Sheet on how to use the electronic CRS Tool module
- A Frequently Asked Questions document.

Based on the pilot results, the use of the CRS Tool increased staff awareness of the safety risks they may be exposed to and improved staff hazard and risk identification. The CRS Tool was also effective in promoting consistent implementation of risk assessment practices across VCH, and facilitating communication among clinicians and between programs.

Education and training for all community staff was an integral part of the project; designated educators rolled the CRS Tool out to all users.

Discussion

Throughout the CRS Tool development process, a number of challenges were encountered including:
- The diversity within the Community Care sector (i.e. variation in information sharing procedures, different control plans in different regions, geographic spread of the Health Authority);
- The creation of an electronic information system tool which was not in the initial project charter;
- Resistance to a new process (i.e. the CRS Tool takes time to complete and may be perceived as more work);
- Unanticipated delays (e.g. due to the H1N1 outbreak and 2010 Olympics); and Scope creep.

Challenges were overcome with senior executive level commitment to the project, the creation of a Health Authority-wide policy to support the CRS Tool, and clear direction from the Steering Committee which had the authority to ensure that the project remained within scope. Integration of the CRS Tool into the electronic information system was needed in order for use and sustainment in all community programs.

Stakeholder engagement throughout the CRS Tool development process contributed to the creation of an effective tool and helped to ensure staff buy-in. Management support, user engagement, communication with all stakeholders throughout the CRS Tool development process and the creation of a supporting policy was crucial to the success of the project. Education and training was an integral part of the CRS Tool implementation.

It has been shown that improved staff safety leads to better quality client care. Increased staff awareness around risks and risk mitigation will reduce staff exposure to and decrease workplace injuries and time loss claims. This general risk assessment tool and process implemented for community workers as a best practice can be easily adapted for use globally throughout health care.

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Learning objectives

1. Introduce a regional strategy to improve staff safety and assist in managing violence and aggression.
2. Demonstrate that management support, policy, education & training can create a quality safety culture and minimize risk of violence & aggression.

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The introduction of an instrument for early detection of aggressive behavior in a psychiatric ICU: Development, implementation and evaluation

Workshop

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Focus: Research

Abstract

Background

The potential for patient violence is a significant issue in psychiatric wards. A review (Choe, Teplin, & Abram, 2008) of four studies conducted in the United States revealed a high prevalence of aggressive behaviour (AB) in adult psychiatric units. Indeed, physical aggression against others may be displayed by more than 20% of hospitalized patients. Furthermore, the Royal College of Psychiatrists' National Audit of Violence in the United Kingdom found that a third of inpatients had experienced violent or threatening behaviour while in care (McGeorge, Shinkwin, & Hinchcliffe, 2006-7). These adverse events can cause significant distress and sometimes injury. They are thought to contribute to high sickness levels, high turnover, and high vacancy rates among staff (Needham et al., 2005), and they may even provoke moral distress (Moran et al., 2009) and symptoms of Post Traumatic Stress Disorder (Bowers, Alexander, Simpson, Ryan, & Carr-Walker, 2007).

Predicting violent behaviours in order to better manage the risk of aggression is thus of great importance for inpatient psychiatry, especially in high-risk environments. Two different categories of assessment tools exist to gauge the risk of future violence. One category is informed by the actuarial model and inventories violent-behaviour risk factors with a view to generating a total risk score. These scales are of value in assessing static risk factors, such as past violence, but they are less useful for planning treatment since the factors are not amenable to change through intervention (Chu, Thomas, Ogloff, & Daffern, 2011). The other category comprises structured clinical guides that consider both static and dynamic factors, such as compliance with medication. Dynamic factors are especially interesting, for they can be changed by intervention. However, in most of these scales the time frame for violence prediction is at least one month (Chu et al., 2011). To evaluate the day-to-day or short-term (within 24 hours) risk of violence in inpatient psychiatry, Almvik, Woods, and Rasmussen (2000) developed the Brøset Violence Checklist (BVC). This scale gauges the imminent risk of aggression on the basis of six different dynamic factors that are recorded as being either present or absent: 1-Confusion, 2-Irritability, 3-Boisterousness, 4-Verbal threats, 5-Physical threats, and 6-Attack on objects.

More recently, Ogloff and Daffern (2006) argued that not all items on the BVC are generally amenable to staff intervention. They developed a new scale, the Dynamic Appraisal of Situational Aggression (DASA), based on the BVC. The DASA is composed of seven items including two from the BVC (Irritability and Verbal Threats) and five others: 1-Negative attitude, 2-Impulsivity, 3-Sensitive to perceived provocation, 4-Easily angered when requests are denied, and 5-Unwillingness to follow directions. These items were chosen because they were maximally effective in identifying patients at risk of violence within 24 hours (Ogloff & Daffern, 2006). The DASA has shown acceptable to excellent predictive accuracy (Chu et al., 2011). Moreover, Ogloff and Daffern (2006) found, the scale was more accurate than unaided clinical judgement based solely on nurses' clinical experience or knowledge of the patient. The staff's perception of the usefulness of the DASA was assessed in a study by Daffern et al. (2009). In this study, the DASA was not well enough established in clinical practice. The tool was thus not deemed useful, and nurses did not perceive such a method for assessing aggression risk as an improvement on their clinical judgement. The authors concluded that it is important for nursing staff to adapt the scale to their clinical needs and to implement it in the context of a broader perspective on managing AB.

Goal

This study seeks to evaluate the predictive validity of the French version of the Dynamic Appraisal of Situational Aggression (DASAfr) and describe the clinical effects on frequency of seclusion and restraint, on caregivers' attitudes and quality of work life and on psychiatric nurses' perceptions of the clinical usefulness of the scale.

Method

A collaborative research design comprising three phases—before, during and after introduction of the DASA—was used. The study was conducted in a 15-beds psychiatric intensive-care unit in a large adult general psychiatric hospital in the province of Quebec (Canada) between November 8, 2010, and June 7, 2011. The DASAfr was filled out three times a day, at the end of each shift. The nurses also reported if an act of aggression (against objects, other people or staff) had occurred during the previous 8 hours and if they had used preventive coercive measures (seclusion with or without restraints) to decrease the risk of aggression. At the different phase

of the study, individual interviews and focus groups were conducted with the nursing staff. The predictive accuracy of the DASAfr was evaluated with the receiver operating characteristic (ROC) curve method (Hosmer & Lemeshow, 2000). The t-test was used to evaluate differences between groups on continuous variables such as age. The Phi coefficient was used to evaluate the effect size of the association between such categorical variables as aggression and seclusion with or without restraints.

Data from the structured questionnaire were grouped into each category provided (relevance, usefulness, clarity of the DASAfr checklist). The focus groups' discussions were recorded and transcribed verbatim. The data were subjected to conventional content analysis: search for significant segment, preliminary coding and emerging coding, interrater agreement on the classification (Miles and Huberman, 2003).

Findings

During the study period, 77 different patients were admitted. The median length of stay was 27 days (1 to 172 days). More males (61% or n = 47) were admitted. Mean patient age was 36.4 years (18 to 69 years). The principal psychiatric diagnoses were schizophrenia (25%. n = 19), schizoaffective disorder (23.7%, n = 18), bipolar disorder (34.2%, n = 26), other psychoses (3.9%, n = 3), major depression (6.6%, n = 5), and personality disorder (6.6%, n = 5). During the study period, aggression against objects was reported 85 times for 28 patients (36.4% of the sample), aggression against others 14 times for 8 patients (10.4% of the sample), and aggression against staff members 28 times for 8 patients (10.4% of the sample). No significant differences in terms of gender or principal diagnosis were found between patients displaying violence against objects, others or staff members. The DASAfr was completed 3798 times. We found that the total score had little ability to predict aggression against objects (AUC= 0.66, CI= 0.58 -0.73) but had acceptable predictive accuracy for aggression against others (AUC= 0.73, CI= 0.57 – 0.89) and against nursing staff (AUC= 0.72, CI= 0.59 – 0.85). Predictive accuracy was similar for both the next shift and the next 24 hours. The nurse's final clinical judgement had the same predictive accuracy as the total score on the DASAfr, and indeed final clinical judgement and total DASAfr score were strongly correlated with each other (Pearson $r = 0.75$; $p < 0.001$). No difference was detected in the frequency of seclusion and restraint during the three-time study.

However, in the focus groups in T1 and T3, the care providers discussed the positive aspects of the DASA. In their view, it is a vital, integrated tool that helps support clinical judgment and prevents aggressive escalation by allowing them to intervene more quickly. It provides an integrated picture of the risk of aggressive behavior and interventions performed by pointing out at a glance those that have been efficacious and by giving indications for adjusting medication. There were also deemed to be barriers to the utility of the DASA checklist. Some care providers felt they were not concerned, considered it just another useless form to fill out and worried about the risks involved in blindly placing their trust in a form rather than in their clinical judgment. Still, in the final focus group, the care providers expressed interest in continuing research activities that have clinical implications and in conducting systematic post-seclusion reviews. The care providers' positions on the advantages and disadvantages of using an instrument for the clinical assessment of aggression risk are similar to those found in the literature. On the one hand, they liked having an instrument to support their judgment, one that prompts daily discussion of their understanding of what is involved and enables them to monitor their patients' progression on a daily basis (Daffern & al., 2009). On the other hand, they fear that, as Lakerman (2006) pointed out, using the forms might lead to the standardization and technologization of care to the exclusion of clinical judgment. Like the Royal College of Psychiatrists (2008), they worried too about a false sense of security that might be induced by a belief in the absolute predictive power of the DASA.

Implication

The DASAfr appears to be a useful tool for predicting and managing aggression in psychiatric facilities. Further research is needed to determine the validity of the scale and to identify the positive factors associated when the implementation of DASAfr. is successful. The participatory research approach must be continued to ensure the implementation of clinical tools.

Key messages

1. The French version of the Dynamic Appraisal of Situational Aggression (DASAfr) has good predictive accuracy for violent physical behaviour
2. The DASAfr was well accepted by the psychiatric nursing staff, and the team perceived the scale as useful to their clinical practice.
3. The DASA is an appropriate tool for sparking dialog among care providers regarding their understanding of aggression.
4. Collaborative research facilities the implementation of clinical tools.

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Learning objectives

1. The French version of the Dynamic Appraisal of Situational Aggression (DASAfr) has good predictive accuracy for violent physical behaviour
2. The DASAfr was well accepted by the psychiatric nursing staff, and the team perceived the scale as useful to their clinical practice.
3. The DASA is an appropriate tool for sparking dialog among care providers regarding their understanding of aggression
4. Collaborative research facilities the implementation of clinical tools

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Staff perceptions of disruptive patient behavior: Survey development

Poster

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Focus: Organisational

Abstract

Background and context

Disruptive patient behavior (DPB), including physical or verbal aggression toward staff, is a common occurrence with a major impact on the safety culture within hospitals. Despite the importance of this issue, we are unaware of a standardized measure to benchmark the frequency and severity of DPB within or across institutions. Nor is there a standard approach to capturing staff perception of the key contributors to DPB, including both patient/family and staff-related factors. Here we report on our initial progress in developing a validated instrument to fill this gap.

Methodology

An initial four-question qualitative survey asking about experience with DPB was completed by 769 staff members (including 510 Registered Nurses) at a large academic medical center. A qualitative descriptive approach using content analysis and theme identification yielded 3 specific themes. A definition of each theme was then generated along with a selection of representative quotes that actualized the respective theme. Data an analysis was exposed to a panel of experts to establish agreement (100%) with the themes identified.

Findings

The qualitative analysis showed good overall fit with extant literature in identifying three major themes related to DPB: preventative approaches (including better management of neuropsychiatric conditions), ready access to training and expertise (including security staff and psychiatric consultation), and the value of post-event follow-up (including both staff support and clinical guidelines development). Questions were then generated from the qualitative analysis and additional literature review. Sixty- five (65) questions have been developed and have been reviewed by a panel of experts for content validation as well as legibility and comprehensibility. Identification of the psychometric properties of a new DPB survey will be established following future data collection.

Implications for management

Results from the analysis identify a survey of the staff perceptions of DPB and represents an initial step toward hot-spotting both areas of concern within the hospital, as well as identifying relative needs (clinical, educational, and managerial) associated with these DPB. When completed, the new DPB survey could also be used to evaluate the effectiveness of evidence driven interventions and establish benchmarks for cross-institution readiness in managing this complex issue.

Learning objectives

1) To demonstrate the need for standardized measures of staff perception of disruptive patient behavior.
2) To demonstrate that training and competency on preventative steps, ready access to assistance, and post-event support appear to be key factors associated with adequate management of disruptive patient behavior.

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Do workplaces at increased risk for patient related workplace violence have an increased risk of co-worker conflict and bullying?

Paper

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Focus: Research
Keywords: Bullying, coworker conflict, impact of bullying, mental health employees

Introduction and background

Workplace violence is an enormous problem worldwide, one that has received increased attention in the U.S. and elsewhere over the past decade (Duhart, 2001; Di Martino, 2002; BLS, 2006; NIOSH 2002; Peek Asa, 2002; Peek Asa, 2009; Lipscomb et al, 2002). Workplace violence is defined as *"violent acts, including physical assaults and threats of assault, directed toward persons at work or on duty"* (CDC /NIOSH, 1996). In the U.S., workplace violence has been classified into four types: Type I (Criminal Intent), Type II (Customer/client), Type III (Worker-on-Worker), and Type IV (Personal Relationship) (UIIPRC, 2001). This paper presents findings from a large survey of state government workforce with a focus on the prevalence and consequences of Type III violence across a range of workplaces in four state agencies. We also present Type II data collected from one of those agencies and discuss possible explanations for their co-occurrence in our data. Finally, we present data collected during a large focus group with staff in the mental health agency as part of the development of an intervention to address Type III violence. These qualitative data provide insight to the finding of the co-occurrence of Type II and III incidents in the mental health work setting.

Methods

Participatory Action Research (PAR) methods were used in the design and implementation of the study, including the formation of a Project Advisory Group (PAG) that included management and union representatives. Surveys were completed electronically at the University of Maryland-Baltimore's secure website, typically during work time. Type III violence was measured via six questions selected from among the 22 items of Einarsen's Negative Act Questionnaire (NAQ) as well as by a standard definition for bullying (Einarsen and Skogstad, 1996). The six questions were selected after the full 22-item NAQ was administered to employees of a pilot agency. The PAG felt that 22 items was too numerous, would take too long to administer, and would likely result in virtually all respondents saying *"yes"* to at least one question. For those reasons, six questions that describe some of the more serious negative acts were selected. The 6-question NAQ demonstrated a good internal reliability, with Cronbach's alpha=0.899 for the overall sample. The six NAQ questions can be paraphrased as: (1) been humiliated or ridiculed; (2) had insulting or offensive remarks made about you; (3) been intimidated with threatening behavior; (4) been ignored or shunned; (5) been subjected to excessive teasing and sarcasm; (6) been shouted at or targeted with spontaneous anger or rage. Bullying was defined as *"abusive behavior (at work) repeated over a period of time and when the victim experiences difficulties in defending him or herself in this situation. It is not bullying if the incident does not occur repeatedly."*

As per Hoel 2001, we categorized the presence of bullying based on the subjective question as *"no bullying"*, *"occasional bullying"* (defined as less than once per week); or *"regular bullying"* (defined as at least once per week). In an effort to also evaluate the prevalence of and factors related to negative acts in the absence of self-identifying as a *"victim of bulling"*, we further categorized those who reported *"no"* to the subjective bulling question into three categories. Those reporting one or more of the six negative acts at least weekly (but no *"bullying"*) were categorized as *"regular NAQ"*; those reporting one or more negative act less than once per week in the past six months (but no *"bullying"*) were categorized as *"occasional NAQ"*; and those who reported no NAQ (and no *"bullying"*) in the past six months were categorized as *"none"*. This coding allowed us to evaluate the combined subjective and objective measures of bullying as five mutually exclusive categories.

Four agencies were included in the survey. Collectively, they provided a variety of government functions, including administrative, regulatory, mental health, and maintenance of the state's highway system. At each participating agency, an agency-level PAG was formed to help ensure that the survey would be well-received and to assist in encouraging a high response rate.

Since the focus of this research was coworker conflict, we did not assess Type II (client on worker) violence across agencies. However, at the request of both management and the unions at one agency, we included , a set of questions on Type II violence in their survey. This agency, which provided a range of services including administrative, field and road maintenance activities, had never been surveyed on the topic of workplace violence and as such had an interest in assessing the prevalence of violence toward workers perpetrated by the *"driving public or a client"*. The questions included in this survey asked about being *"verbally threatened or abused"*, *"physically confronted or assaulted"* and *"intentionally hit by a vehicle"* in the past twelve months.

Response options ranged from *"never"* to *"once per day"*. Approval for all surveys was obtained from the University of Maryland-Baltimore.

Results

A total of 12,546 completed surveys were collected from four agencies (72% response rate), including 1,040 from three mental health (MH) facilities and 4,592 from the transportation agency. The three MH facilities are part of a state-run system of 26 facilities. The system provides a wide range of MH services, including: in-patient adult, both general and forensic; inpatient youth; community residential; and outpatient. The three facilities selected provide all of the above-mentioned services, other than forensic inpatient. They were selected for the survey based on their representativeness, both programmatic as well as geographic, and the interest of the facility managers and union representatives in participating.

When examining the prevalence of Type III by the type of work setting, MH respondents reported a higher prevalence of workplace conflict compared with workers employed in the other three state agencies (Table 1). Among workers employed by the MH agency, those who work on in-patient units reported significantly higher prevalence of conflict than MH workers in the outpatient and administrative units. Among all MH workers, 57% reported experiencing some form of negative acts or bullying in the past six months compared with 32% among workers in the administrative/field agencies. One hypothesis proposed for the higher prevalence of Type III in the MH agency (and supported by subsequent qualitative data) is that the stress of dealing with potentially violent clients leads to hostility and conflict among staff. When we examined the prevalence of Type III across all 12,456 workers by work area we found a statistically significant trend in increasing Type III violence with increasing risk of Type II violence, with the prevalence among transportation workers assigned to field offices and highway maintenance less than among MH workers but higher than among administrative workers (Table 1).

Table1. NAQ and Bullying in 5 categories

	No bully & no NAQ	>=1 NAQ occasionally & no bully	>=1 NAQ regularly & no bully	Bully occasionally	Bully regularly
MH Institutional	107 (38.1%)	115 (40.9%)	14 (5.0%)	37 (13.2%)	8 (2.8%)
MH Field	158 (51.3%)	97 (31.5%)	15 (4.9%)	26 (8.4%)	12 (3.9%)
MH Admin	35 (54.7%)	22 (34.4%)	1 (1.6%)	5 (7.8%)	1(1.6%)
Other-Admin	3750 (61.5%)	1601 (26.3%)	273 (4.5%)	375 (6.2%)	95 (1.6%)
Other: Field	1654 (61.8%)	687 (25.7%)	120 (4.5%)	165 (6.2%)	51(1.9%)
Other: Road crews	601 (43.3%)	409 (29.4%)	173 (12.5%)	134 (9.6%)	72 (5.2%)

We then examined Type II and Type III data from the transportation agency workers who work in the field and have contact with the driving public, a potential source of Type II violence. We found a significant dose response relationship between all three Type II outcomes and our five levels of coworker conflict (Tables 2-4).

Findings from one large focus group with MH staff provided important insight into the high prevalence of coworker conflict in the MH work setting. First, workers suggested that as MH is a highly stressful work environment and that staff misconduct toward patients is not tolerated, staff perceive that it is safer to *"lash out"* at other staff. They noted that staffing reductions, constraints around the use of restraint and seclusion (R/S) and the potential consequences to staff if R/S were used, all contribute to high stress situations. They also noted that the lack of the opportunity for staff to decompress/ debrief following a patient intervention is a contributor. Staff noted that, particularly in the children's unit, disagreement about how to handle disruptive and/or violent youth can lead to staff conflict. When asked how to intervene to reduce coworker conflict, staff recommended that more time is needed for debriefing following stressful incidents. In addition, they noted that when staff are assaulted, police and the district attorney often will not press charges and the assaultive patient remains in the facility. There are ongoing efforts at the facilities to reduce workplace violence, including a workgroup at one facility directly addressing coworker conflict.

*Table 2. Past 12 months verbally abused or threatened by non-employee (Type II) * NAQ and Bullying in 5 categories*

	No bully & no NAQ	>=1 NAQ occasionally & no bully	>=1 NAQ regularly & no bully	Bully occasionally	Bully regularly
Never	1264 (65.3%)	472 (24.4%)	116 (6.0%)	67 (3.5%)	16 (0.8%)
Once	92 (32.5%)	126 (44.5%)	31 (11.0%)	29 (10.2%)	5 (1.8%)
More than once	117 (24.2%)	182 (37.6%)	62 (12.8%)	85 (17.6%)	38 (7.9%)
At least once monthly	13 (10.7%)	26 (21.5%)	26 (21.5%)	37 (30.6%)	19 (15.7%)
At least once per day	1 (2.1%)	3 (6.3%)	8 (16.7%)	6 (12.5%)	30 (62.5%)

*Table 3. Past 12 months physically confronted or assaulted by non-employee (Type II) * NAQ and Bullying in 5 categories*

	No bully & no NAQ	>=1 NAQ occasionally & no bully	>=1 NAQ regularly & no bully	Bully occasionally	Bully regularly
Never	1444 (55.3%)	738 (28.2%)	207 (7.9%)	169 (6.5%)	55 (2.1%)
Once	29 (25.0%)	39 (33.6%)	17 (14.7%)	18 (15.5%)	13 (11.2%)
More than once	31 (24.8%)	36 (28.8%)	17 (13.6%)	26 (20.8%)	15 (12.0%)
At least once monthly	0 (0%)	2 (9.1%)	3 (13.6%)	8 (36.4%)	9 (40.9%)
At least once per day	1 (5.0%)	1 (5.0%)	3 (15.0%)	1 (5.0%)	14 (70.0%)

*Table 4. Past 12 months intentionally hit by a vehicle by non-employee (Type II) * NAQ and Bullying in 5 categories*

	No bully & no NAQ	>=1 NAQ occasionally & no bully	>=1 NAQ regularly & no bully	Bully occasionally	Bully regularly
Never	1448 (53.9%)	757 (28.2%)	222 (8.3%)	191 (7.1%)	69 (2.6%)
Once	25 (29.1%)	30 (34.9%)	9 (10.5%)	12 (14.0%)	10 (11.6%)
More than once	24 (26.4%)	26 (28.6%)	12 (13.2%)	16 (17.6%)	13 (14.3%)
At least once monthly	0 (0%)	2 (18.2%)	1 (9.1%)	3 (27.3%)	5 (45.5%)
At least once per day	1 (6.7%)	1 (6.7%)	1 (6.7%)	1 (6.7%)	11 (73.3%)

Discussion

This large survey allowed us to examine the prevalence of Type III violence across a range of state government workplaces. Study strengths includes a large sample size, a high response rate, and the use of standardize, valid measures of Type II and III violence. A somewhat unexpected finding in the overall analysis was the significantly higher prevalence of coworker conflict among workers in the MH agency. Upon discussion with MH workers and exploratory analysis of data from a second agency where we collected both Type II and III data, we suggest that working with potentially violence clients/the public may increase the risk of coworker conflict by creating a highly stressful environment where it may be more acceptable to retaliate against coworkers than members of the public they service. These data are preliminary and in the case of the data from the transportation agency, provide the perspective of the worker/recipient of the violence. Further study is needed to validate these data and better understand the relationship between the various types of workplace violence.

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Learning objectives

1. Participants will be able to describe risk factors common to both Type 2 and Type 3 workplace violence.
2. Participants will be aware of interventions designed to address both type of violence in the mental health setting.

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Mitigation and response to gender-based violence in Moroto District, North Eastern Uganda

Paper

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Focus: Practice
Keywords: Mitigation, response, gender-based violence

Abstract

Patterns of violence against women differ markedly from violence against men. For example, women are more likely than men to be sexually assaulted or killed by someone they know. The United Nations has defined violence against women as gender-based violence, to acknowledge that such violence is rooted in gender inequality and is often tolerated and condoned by laws, institutions, and community norms. Violence against women is not only a profound violation of human rights, but also a costly impediment to a country's national development. While gender-based violence occurs in many forms throughout the life cycle, this review focuses on two of the most common types - physical intimate partner violence and sexual violence by any perpetrator. Unfortunately, the knowledge base about effective initiatives to prevent and respond to gender-based violence is relatively limited. Few approaches have been rigorously evaluated, even in high-income countries. And such e valuations involve numerous methodological challenges. Nonetheless, the authors review what is known about more and less effective - or at least promising - approaches to prevent and respond to gender-based violence. They present definitions, recent statistics, health consequences, costs, and risk factors of gender-based violence. The authors analyze good practice initiatives in the justice, health, and education sectors, as well as multisectoral approaches. For each of these sectors, they examine initiatives that have addressed laws and policies, institutional reforms, community mobilization, and individual behavior change strategies. Finally, the authors identify priorities for future research and action, including funding research on the health and socioeconomic costs of violence against women, encouraging science-based program evaluations, disseminating evaluation results across countries, promoting investment in effective prevention and treatment initiatives, and encouraging public-private partnerships.

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Addressing staff and patient safety through electronic patient record (EPR) violent behaviour alerts: A clinical and technology partnership

Paper

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Focus: Organisational

Abstract

In June 2010, all Ontario, Canada workplaces were mandated through a change in Occupational Health and Safety (OHS) Act (Bill 168) to develop and implement a response to prevent or manage workplace violence. Elements of the legislation require policy, risk assessment, identification of individuals who are at risk or are exhibiting violent behaviour, reporting as well as other response processes.

University Health Network (UHN), a large urban multi-site acute care hospital with over 11,000 employees has developed an Electronic Patient Record (EPR) solution to flagging patients/related visitors with actual or risk of violent behaviour. An electronic desktop solution improved easy access to timely violent behaviour alerts (VBA)s for all staff, across all programs, across all visit types both at initial patient contact and subsequent repeat visits as needed.

The EPR VBA solution was developed through a partnership between Clinical Best Practice and Information Technology (CBPIT) Committee with a mandate for optimizing the capacity and usability of the EPR and UHN Workplace Violence Committee (WPVC) which addresses organizational processes and structures to support Bill 168. Extensive review of the literature and other organizational protocols were initiated. Results of those reviews indicated that many hospitals are identifying patients at risk for violence but none had developed an electronic EPR option. Embedded in the VBA development and implementation processes both committees were involved in rigorous debate between the staff safety imperative of Bill 168 and the balance with patient privacy and the risks of labeling patients.

Ultimately, integrated work between the two interprofessional committees including human factors usability testing developed an EPR VBA which identifies patients and/or their related visitors that are temporarily or permanently at risk for violent behaviour. There is a standardized process with specific criteria including both clinical team recommendation and hospital Risk Management endorsement for approving those patients/visitors flagged as a permanent risk. For those patients/visitors identified as episodic risk the VBA will be initiated upon admission with default for automatic removal upon discharge unless otherwise indicated by the clinical team. Removing the VBA from a patient that has been permanently flagged only occurs through a standardized hospital Risk Management approval process. VBAs include identification of the person exhibiting violent behaviour, details of the behaviour, contributing factors and response or de-escalation strategies. While response strategies are not included in a requirement for Bill 168 it was felt to be an important addition to the project to improve staff/patient safety and the quality of patient care. VBA information is included within the EPR Chart Review and is also available for quick access when staff hovers over the commonly used EPR Caution icon on the front page of the desktop.

Implementation of VBA is planned for May 2012, with full evaluation throughout the summer. It is one element of a comprehensive violent behaviour response algorithm and complex patient care planning response process which is well supported and valued throughout the organization.

Learning objectives

1. To describe the process of how clinical and technology experts within an acute care setting partnered to develop an innovative Violent Behaviour Alert (VBA) in the Electronic Patient Record (EPR).
2. To review the content, electronic design and implementation of the EPR VBA tool.

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Prevention of workplace violence in out-of-hours primary care centres – a cross-sectional study

Paper

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Focus: Research
Keywords: Workplace violence, out-of hours primary care centre, safety, prevention

Introduction

Employees at out-of-hours (OOH) primary care centres in Norway have raised concerns about personal safety and lack of adequate security precautions regarding workplace violence. Workplace violence can be defined as *"incidents where an employee is abused, sexually harassed, or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health"* (1). A recent study has shown that the prevalence of workplace violence in Norwegian OOH primary care centres is high (2). One in three employees has been physical abused during their OOH career (2).

In Norway, the local municipalities are by law responsible for the 24/7 emergency medical services for all inhabitants (3). During office hours the emergency medical service is usually managed at general practitioners clinics, whilst OOH primary care centres provide emergency care during evenings, nights, weekends and public holidays. Some of the OOH primary care centres are organized as co-operations between two or more municipalities. Staff on duty at any given time varies from one to several persons, including doctors (mandatory), nurses and other health personnel (4). The doctors primarily consult patients at the OOH primary care centre, but they also do home visits and participate at site in emergencies outside hospitals (5). When nurses or other health personnel are available, they often perform triage in the patient's initial contact with the centre, give advice when appropriate and assist the doctor when needed.

Due to Norway's strict two-leveled health care system no patients can present themselves directly to hospital emergency departments. Thus a referral from a doctor at an OOH primary care centre is a prerequisite for out-of-hours access to secondary care. Patients self-refer to the OOH primary care centres. By policy the centres are easily accessible to the public, and they handle all types of emergencies including behavioural emergencies.

Despite the established high risk for workplace violence at OOH primary care centres, there has been little focus on prevention of workplace violence. There is little information available regarding preventive measures applied in the centres. Knowledge of existing safety measures is a necessary prerequisite for further improvement of preventive practices. Thus, the aim of this study was to investigate the prevalence of preventive measures against workplace violence in OOH primary care centres in Norway.

Methods

During the first months of 2012 a web-based questionnaire was sent to the manager for each of the 210 registered OOH primary care centres in Norway (4). The questionnaire was sent as part of an update of the National register of out-of-hours services in primary health care, and the questionnaire was therefore not anonymously answered. The web questionnaire was constructed so that all questions had to be answered. Hence, if the questionnaire was answered, there were no missing data. The questionnaire included a list of 22 possible safety measures based on recommendations from the Norwegian Association of General Practitioners (6). For analytic purposes, the 22- item list was grouped into five different categories of preventive measures: Reception, consulting room, electronic safety systems, available staff and education/monitoring system. For an overview of the list and the categorization, see Box 1. The data were analysed using SPSS version 19.

Box 1. List of occupational safety measures in out-of-hours primary care centres

Reception
- Barrier/glass partition between reception and waiting room
- View to the entrance
- View to the waiting room
- Sheltered room

Consulting room
- Patient NOT sitting between the clinician and door
- Quick entrance/exit for staff
- Alternative exit

Electronic safety systems
- CCTV camera (closed-circuit television)
- Automatic door lock
- Alarm on medical radio network
- Panic button by desk/keyboard
- Panic button on wall
- Portable alarm
- Alarm linked to alarm center
- Poster with information about alarm

Available staff
- Always more than one person on duty
- Personnel continuously accessible for patients/visitors
- Routine for extra person on call-out/home visits when needed for security reasons
- Security guard

Education and monitoring system
- Education regarding threats/violence against personnel
- Incident reporting of threats/violence against personnel
- Follow-up of employees after experienced incidents of threats/violence

Results

A total of 203 (97%) of the 210 eligible OOH primary care centres answered the questionnaire.

Reception

54 (27%) of the OOH primary care centres reported that they had applied all measures regarding physical environment in reception area, i.e. barrier between reception and waiting room, view to the entrance and to the waiting room, and a sheltered room. 14 (7%) of the centres had none of the four listed measures. The most frequently applied measure was a barrier or glass partition between the reception and the waiting room, reported by 176 (87%) of the centres.

Consulting room

38 (19%) of the OOH primary care centres had applied all three measures regarding physical environment in the consulting room; arranged the furniture so that the patient was not sitting between the clinician and the door, quick entrance/exit for staff, as well as alternative exit from the consulting room. 55 (27%) of the centres had none of the listed measures. The most frequently applied measure was alternative exit, applied by 120 centres (59%).

Electronic safety systems

One OOH primary care centre (0.5%) reported that they had all measures in the electronic equipment category, including close-circuit television camera (CCTV camera), automatic door lock, alarm on medical radio network, panic button by desk/keyboard, panic button on wall, portable alarm, alarm linked to alarm center, and poster with information about alarm. Nine (4%) of the centres did not have any of the eight measures. Medical radio network was the electronic safety system used most often, applied by 155 (74%) of the OOH primary care centres.

Available staff

Four (2%) of the OOH primary care centres had all items in the available staff category, which means that they always had more than one person on duty, personnel continuously accessible for patients/visitors, routine for extra person on call-out/home visits when needed for security reasons, and security guard at the centre. 68 (34%) of the centres had none of the four given items. Only 61 (30%) of the centres had always more than one person on duty.

Education and monitoring system

75 (37%) of the OOH primary care centres had applied all three measures regarding education and monitoring system: Education regarding threats/violence against personnel, incident reporting of threats/violence against personnel and follow-up of employees after experienced incidents of threats/violence. 35 (17%) reported that they had none of the three measures. Most of the centres, a total of 150 (74%), answered that they had a system for follow-up after experienced incidents of threats/violence.

Discussion

To our knowledge, this is the first study on applied preventive measures in OOH primary care centres in Norway. The variation in number of applied occupational safety measures in the Norwegian OOH services may reflect the varying organizing of the service in different parts of the country. The finding that only 30% of the centres

always had more than one person on duty shows that the doctor works alone at the majority of the centres at least part of the opening hours, which makes them more vulnerable if violent situations occur.

Strength and limitations

This study's strength is a very high response rate. The results are therefore most likely representative for Norwegian OOH primary care centres. However, non-anonymity of the questionnaire could have affected the validity of the study. The managers might have a personal or political agenda for making a good - or even bad - picture of the situation at the centre as part of a strategic communication with the authorities. The list of measures used in our questionnaire was based on recommendations from the Norwegian Association of General Practitioners and not on specific recommendations for OOH primary care. Due to differences in occurrence and types of violence, the recommended list may include measures of limited relevance to Norwegian OOH primary care centres. Also, the list may lack preventive measures that could be essential to the out-of-hours setting (7). However, as we did not find a specific list of recommended measures in OOH primary care, the presented list may be a valuable start in getting a picture of applied preventive measures in this service.

Physical environment of reception and consulting room

The reception in most of the centres was designed with barrier/glass partition around the reception desk as well as with a view to the entrance and waiting area. These features are recommended to maximize a safe working environment in primary care buildings, despite potential conflicts between ease of access, confidentiality and safety (8). A study on receptionists' perception of having a perspex shield at the reception desk concluded that this safety measure may have adverse effects on patient-staff relationships, exacerbate violence and increase staff fearfulness (9). Understanding the function of space, symbolically and practically, and how to use barriers, doorways, and privacy is essential in health care (10). The finding of seven percent with no applied measures in the reception area may simply reflect the small size of some Norwegian OOH primary care centres, where the doctor works alone and does not have any staffed reception area.

Almost one of three centres did not have any of the three recommended measures regarding arrangement of the consulting room. Some of these measures are difficult to implement without changing the building structure, and must therefore be remembered in the initial planning phase of a new OOH centre. This finding might indicate that prevention of work-related violence is often forgotten when planning or designing the centres.

Electronic safety systems

Almost all OOH primary care centres in Norway had one or several alarm possibilities in case of violence or threats against OOH personnel. 'To have alarm systems to alert colleagues or others in the event of a problem is strongly recommended (10, 11). Still, four percent did not have any alert system, which seriously restrict their ability to get help when needed.

Available staff

One of three OOH primary care centres reported that they had none of the four measures from the list regarding available staff. Thus a substantial share of the health personnel works alone even in situations where extra security is needed. The presence of co-workers has been identified as a potential deterrent to assaults (12) and has also been officially recommended for emergency primary health care services in Norway (13). It is therefore worrying that health personnel still sometimes or always work alone in 67% of the centres.

Education and monitoring system

A monitoring system for threats and violence is a highly recommended organizational measure to prevent occupational violence and consequences thereof (1, 8, 10). Violence-prevention training is deemed important and useful to prevent workplace violence in the health sector (10, 11, 14). Although monitoring systems seems relatively prevalent, there is obviously a potential for improvement in many of the Norwegian OOH primary care centres regarding education of staff.

Conclusion

This study shows a considerable variation between Norwegian OOH primary care centres regarding applied preventive measures. More information is needed to judge appropriateness of different measures and to make better recommendations for the centres. Given the variation in organization and size of the centres, we cannot assume that all suggested measures should be implemented everywhere. Further research should therefore focus on the nature of violence in OOH emergency primary care, experiences of actual benefit of applied preventive measures and the effects of interventions regarding occurrence and consequences of violence.

Acknowledgements

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Short-Term Assessment of Risk and Treatability (START): An introduction and summary of research evidence

Paper

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Focus: Research

Abstract

Risk assessment and management of mentally ill individuals is a central aspect of a clinicians daily responsibilities. In recent years, there has been a significant advancement in the development of risk assessment and management procedures, yet there is little evidence that many of these procedures have been implemented into daily practice. Further, many of the risk assessment measures developed to date focus on long-term outcomes (i.e., more than one year) and concentrate on risk factors with little consideration of clients strengths or protective factors (Rogers, 2000; Webster et al., 2006). The Short-Term Assessment of Risk and Treatability (START; Webster et al., 2004, 2009) is a relatively new structured professional judgment risk assessment measure that attempts to address these limitations. Through the differential coding of 20 dynamic strength and vulnerability-related factors, START can be used for the assessment of short-term risk in seven do mains that are relatively common and often co-occurring among civil, forensic, and correctional populations: violence, suicide, self-harm, self-neglect, unauthorized leave, substance abuse, and victimization. The use of the START guides clinicians toward an integrated, balanced opinion. It is intended to inform clinical interventions and assist in treatment and risk management plans. START can be used within general mental health, forensic, correctional and probation services.

START has gained considerable international exposure and wide implementation (e.g., eight translations), has increasingly been the focus of research, and has a growing empirical literature. The current presentation will provide the audience with an overview of the START and a summary of important research findings. To begin, we will review the administration guidelines and procedures, provide an overview of the START worksheet, and discuss implementation details (e.g., re-assessment timelines, average time for administration). In terms of research findings, we will provide a summary of the local and international research conducted to date, focusing on reliability, validity, and user satisfaction. For example, research has demonstrated good rater agreement for START assessments across professions (Brink & Livingston, 2004) and independent researchers (Nicholls et al., 2009; Wilson et al., 2010). The START also has consistently demonstrated good validity. START assessments hav e shown strong predictive validity for adverse outcomes, particularly aggression (Desmarais et al., 2012; Haque & Cree, 2009). Petersen and colleagues (2009) have demonstrated the STARTs good convergent and divergent validity properties, as results show strong positive relationships between START Vulnerability scores with HCR-20 and PCL:SV total scores, and strong negative relationships between START Strength scores and HCR-20 total scores, respectively. Finally, users have supported the clinical utility of the START (Collins et al., 2009; Doyle et al., 2008). Overall, research and practice has shown the STARTs usefulness for assessing and managing mentally ill individuals at risk for adverse outcomes, including violence.
From this presentation, the audience will have an understanding of the Short-term Assessment of Risk and Treatability, including how and when it should be used. In addition, the audience will leave with an appreciation of the research evidence supporting its usefulness for managing individuals with mental health issues at risk for multiple adverse outcomes, including violence.

Learning objectives

From this presentation, the audience will
1. Have an understanding of the Short-term Assessment of Risk and Treatability (START, Webster, Martin, Brink, Nicholls, & Middleton, 2004; Webster, Martin, Brink, Nicholls, & Desmarais, 2009), including how and when it should be used.
2. Gain an appreciation of the research evidence supporting the usefulness of START assessments for managing individuals with mental health issues at risk for multiple adverse outcomes, including violence.

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Advancing safety in Canadian health organizations: Accreditation Canada workplace violence prevention Required Organizational Practice

Poster

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Focus: Policy

Abstract

Background

Violence in the work environment is a growing concern for Canadians, particularly in the health care field. Evidence has shown that as many as one-quarter of all incidents of workplace violence take place in the health sector. In partnership with Health Force Ontario, Accreditation Canada began looking at ways to prevent violence in Canadian health care workplaces in 2008. Results from a review of the literature, focus group discussions, and a national consultation informed the development of the Workplace Violence Prevention Required Organizational Practice (ROP) that requires organizations to implement a comprehensive strategy to prevent workplace violence.

Methodology

National Compliance

The Workplace Violence Prevention ROP was introduced to the Accreditation Canada Qmentum program in 2010 and applies to organizations across the health system. Evaluation of the ROP began during accreditation on-site surveys in 2011. Organizational compliance with the ROP is evaluated against eight tests for compliance using a peer surveyor model, and all 8 tests must be met for an overall rating of compliance. The first full year of evaluation was completed in 2011, and an analysis of national compliance rates was conducted.

ROP evaluation

A subset of organizations participated in a detailed evaluation of the ROP. In 2010, 24 organizations completed a self-evaluation assessing their compliance with the ROP. Each organization had minimal exposure to the new ROP but was working towards implementation. In 2011, these 24 organizations were evaluated against the ROP by Accreditation Canada surveyors as part of their on-site survey. A comparison between organizations 2010 self-evaluation ratings and Accreditation Canadas 2011 on-site survey ratings was made to examine the effect of the ROP on advancing workplace violence prevention initiatives.

Findings

National Compliance

Based on 288 on-site surveys of health care organizations in 2011, national compliance with the Workplace Violence Prevention ROP was 85%. Tests for compliance with the highest ratings related to having a documented process in place for staff to confidentially report incidents of workplace violence (98%), and having a written policy for the prevention of workplace violence (97%). Tests for compliance with the lowest ratings related to organizations conducting risk assessments (91%), and organizational leaders reviewing quarterly incident reports to increase safety (93%).

ROP evaluation

For the 24 organizations participating in the detailed evaluation, overall ROP compliance from organizations self-evaluations in 2010 was 48%. Accreditation Canada ratings for these organizations during on-site surveys one year later was 75%. Compliance rates were highest in jurisdictions where workplace violence legislation had been introduced. Rates for specific tests for compliance were similar to the national rates noted previously.

Implications

The Workplace Violence Prevention ROP has been an important lever in advancing workplace violence prevention initiatives in Canada. In jurisdictions where workplace violence initiatives are lacking, the involvement of government or accrediting bodies can promote the uptake of workplace violence initiatives, yet it is imperative that messaging from these organizations remains consistent. Further training is necessary to support organizations with the implementation of workplace violence risk assessments, and to utilize incident report findings to mitigate the future risk of workplace violence.

Learning objectives

1. To provide an understanding of the challenges and successes Canadian health care organizations are experiencing with the implementation of workplace violence prevention initiatives.
2. To promote the sharing of best practices, tools, and resources to support organizations in conducting workplace violence risk assessments, and to utilize incident report findings to improve safety.

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Preventing violent incidents in psychiatry

Poster

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Focus: Policy

History

In psychiatric settings, acts of violence are undesirable incidents for which our union has taken a certain number of preventive and corrective steps in recent years. Our trade union believes that the recording of violent incidents is not enough. We want to take action to prevent violence and involve all employees, Health and Safety and Working Conditions Committees and organizations representing staff. It was with this in mind that the CFDT Santé-Sociaux (Health and Social Work Sector) team participated in the introduction of a violence prevention and management programme into a large public psychiatric institution located in Strasbourg, France that has 1581 employees, including 103 physicians.

Methodology

A working group on the prevention and management of violence was established. An annual report was instituted that enabled the dissemination of information on steps taken to improve the situation, which was based on an analysis of reports of the violent incidents that had occurred.

2003 A security team to protect employees was created. The appointment of two employees trained in the management and control of violent situations and two trained nurses formed a team that gave continuous cover from 6.30am to 9pm and provided the capacity for a rapid response to calls for help or to assist in operations to protect isolated employees.

2004 A victim support procedure was introduced. After a significant reduction in assaults, notably those resulting in serious physical injury, the indicators seemed to level out.

2006 A group of carer-trainers was created with expertise in the use of *"de-escalation techniques"* to manage violent situations and to train employees in how to negotiate, to defuse and resolve these situations.

2007 After the training, there was a proposal for the teams to take what they had learned back to the workplace and adapt it to the specific situation of each service.

Results

In 2010, for the second consecutive year, there was a major reduction in the number of workplace accident reports: 16 compared to 54 in 2004. This was a reduction of more than 60 per cent in workplace accidents reported over 6 years, suggesting the achievement of a more serene and less stressful working environment.

Trade union action

Our union disseminates information to its members about initiatives to prevent and manage violence to encourage them to establish similar arrangements at their workplaces.

Learning objectives

Participants will appreciate that…
1. It is vital to involve and provide advice and support to all staff.
2. It is important for the health care team to be given the opportunity to discuss their work, including their fears and feelings of insecurity.
3. The entire multidisciplinary team should review and debrief on violent incident and on the circumstances at the time that the violence was triggered, as soon as possible after the incident.
4. Sharing good practice is vital in disseminating lessons learned.
5. It is important to train all staff in how to negotiate, defuse and resolve potentially violent situations.

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Prevention and management of violence: A Directional Plan to develop human capital in community nursing

Poster

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Focus: Education and Training

Abstract

Background and context

A healthy work environment maximizes the health and well-being of all staff, quality client outcomes, and organizational effectiveness. The work environment for community nurses is directly in a clients home. Several factors have combined recognizing the community nurse as particularly vulnerable to physical, emotional, and sexual abuse in high crime districts and in the home by clients or others. It is rare that nurses have the skills and ability to manage threats to their personal safety. Human capital development in this area was identified as an imperative to the organization. This presentation focuses on how one community nursing organization in southern Ontario worked to develop a comprehensive Directional Plan to address the issue. As a branch of a national community health care organization, the findings will enjoy broad dissemination and serve to inform complementary partners in community nursing.

Methods

Following the development of a project vision and objectives, the Project Advisory Team planned three distinct phases: Phase 1 aimed to scope out the issue in terms of societal risk metrics, the definition and prevalence of violence perpetrated on the nurse, nurses descriptions of situations of abuse and violence, and current relevant organizational documents; Phase 2 involved the development and staff endorsement of prevention and management strategies that would effect change in reporting, personal management, protection, support and problem resolution; Phase 3 involved the evaluation of data, dissemination and sustainability aspects.

Findings

The plan is nearing the end of Phase 1. A community environmental scan has been conducted. Two fax surveys of staff nurses (n = 80) have resulted in an endorsement of a definition of workplace abuse/violence, and then the attributes of an ideal workplace relative to the issue. All relevant documents have been obtained from the organization and regional community affiliates. The final, Phase 1 step is in preparation: a qualitative exploration of nurses stories of memorable incidents and their suggested strategies for prevention and management.

Implications

This presentation will describe the rationale and development of a plan that involved not only the community nursing staff, but also their community partners, academic affiliates, nursing students, and the public. Work-in-progress findings will be discussed. The overall vision aims to ensure that community nurses deliver high quality care within a context where risks to personal safety are actively recognized, prevented and/or minimized. Participants will engage in exploring the community nursing context, the issue of violence and personal risks, the need for the development of unique skills and competencies, and will learn one organizations 3-phase approach to a directional plan.

Learning objectives

1. To recognize and heighten awareness of the risks of violence to community nurses by clients and within neighbourhoods.
2. To describe and discuss a participative, 3-phase plan to build and evaluate management and violence prevention skills in community nurses.

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Assessment, identification and communication of aggressive behaviour in a healthcare setting

Paper

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Focus: Organisational
Keywords: aggressive behaviour alert, violence alert aggressive behaviour assessment, patient/client/resident violence, patient/client/resident aggression, physical alert tools, electronic alert.

Abstract

Literature supports a standardized communication platform and an aggressive behaviour alert process as key components in mitigating the risk of violent incidents in the healthcare sector. The Interior Health Authority, located in the province of British Columbia, Canada, has successfully implemented the process for the past 3 years..

During the development of this process, stakeholder feedback and trials evolved to include a comprehensive assessment tool (Aggressive Behaviour Assessment Scale) and a two step application process for physical and electronic alerts as well as a documentation procedure. The Alert process involves the use of physical and electronic alerts whereby the physical alert is a purple dot system that is recognized provincially. The electronic process includes a gathering of pertinent patient and environmental information applicable to all sectors in the health authority.

Throughout the implementation of the process, various lessons were learned which identified the uptake and buy in from end users, Specifically, frontline end users were motivated to use physical tools immediately and the 2 step process was necessary in complying with ethics and risk management considerations whereby a 2 step application was required to ensure patient confidentiality and appropriate reasoning/rationale for applying the alert (triggers, risk factors and suggested interventions). It was also necessary to incorporate a review process that allows for an ability to change an active alert to a history alert, a re-admission process, as well as a communication of information to all internal and external partners.

Results will demonstrate that the aggressive alert process helps mitigate the risk of violence for staff and volunteers. This will be demonstrated through staff feedback, surveys, Code White and Aggressive Behaviour data as well as increased effective behavioural care planning.

Interior Health has implemented an aggressive alert process which has proven to be a key component in mitigating the risk of violent incidents in the Interior Health Authority. This implementation supports the literature findings of a standardized communication platform and aggressive behavior alert process as key in reducing violence. Overall, this implementation also recognizes and acknowledges larger system implications in that others can better understand and adopt the key components required for sustained success.

Learning objectives

1. The aggressive alert process requires an assessment tool and an application process of for the physical and electronic components.
2. The electronic alert must include detailed information about the reasons for the alert.

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Violence in the continuing care sector: One organization's experience and response to a critical incident

Paper

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Focus: Organisational
Keywords: Critical incident, violence, root cause analysis, quality improvement

The Good Samaritan Society (GSS) is a Canadian faith-based not-for-profit continuing care provider with over 54 sites and programs spanning the two provinces of Alberta and British Columbia that serve more than 6,000 individuals and 3600 staff. We provide complex/long term care, assisted/supportive living and other specialized health care services for the elderly and the physically and mentally challenged.

Background and methodology

On March 31, 2009, one of our facilities providing assisted living services experienced a critical incident whereby a planned relocation of a resident turned unexpectedly violent when the resident produced a weapon and critically injured a staff member and threatened two others. This unexpected incident resulted in an extensive investigation and analysis of our organizational practices related to residency with a view to mitigate a recurrence in the future.

Our organization's critical incident policy stipulates a specific response to sentinel events and endorses the use of root cause analysis for incident investigation. Through the use of a multidisciplinary team an intensive root cause analysis was completed following the Canadian Patient Safety Institute's root cause analysis framework. The establishment of a timeline assisted in the data analysis and understanding of the event. Fish bone and tree diagrams were utilized to source out contributing factors and ultimately root cause identification. Causal statements were created and served as the basis for the formation of the investigation recommendations. Incidental findings were also identified during the process and were included in the action plan regardless if there was a relationship to the root cause.

The resulting recommendations were categorized into one of three themes: communication, risk management and privacy. The outcomes of this investigation were organized into an integrated action plan document and internal recommendations were prioritized according to impact with measurements for success identified from the beginning. Each actionable item was assigned to a lead person and small work teams set up to facilitate its completion. Internal organizational practices have changed significantly in relation to these three themes.

An assessment of all existing policies, processes and standards was undertaken. While our organization already had many policies in place related to management of violent/aggressive behaviors, it was found that there was not one overall document that contained a comprehensive resource for all staff to reference.

The implications for our organization were significant. This work resulted in many policy changes; well defined move-in and move-out processes were created, the further standardization of documentation and assessment within our electronic health record as well as clinical documentation. Some of these initiatives will be discussed further on.

Our philosophy of care that guides our staff for our continuing care services was in process of being reviewed and has since been completely re-written to affirm our mission, vision and values as a faith based organization and confirm the population that we serve. This philosophy of care has also been shared outside our organization.

This analysis as mentioned above also created a comprehensive violence prevention and response program for all staff and reintroduced the role of risk management in frontline care processes. This program was and is currently being implemented organization wide to all staff with the emphasis being the affirmation of frontline roles and responsibility in the reporting and monitoring of all incidents.

Actionable responses

The root cause analysis and incident review process identified a need to develop clear policy and process around the relocation/removal of residents. In starting this work it became evident that if a relocation policy was to be effective it needed to reflect and be supported in the policy and procedures guiding admission of residents/clients into a program. Although necessary for all programs this presentation will present our work in relation to the assisted/supportive living residents whom we support.

Residents/clients, family members, staff and partners need to know from the beginning the resident/client rights as regards tenancy, their responsibilities as regards tenancy and the reasons that a tenancy would be ended. As an organization the decision was made to review and revise our policy and process from moving in through moving out. This would include clear guidelines on required documentation and communication. The work completed included a complete review and revision of the moving in policy, development of a new moving in agreement, development and implementation of a tenancy agreement and the review and revision of the moving out policy. This work was to reflect the need to clearly identify communication and documentation requirements and address the need to identify and prevent potential violence in the workplace.

Moving In Policy

The development of this policy and procedure was completed by a work group that included provincial staff representation, all programs and relevant support groups in the organization. The policy and procedure addresses the timeline from identification of a potential resident to six weeks after the actual admission when the initial resident/family conference occurs. The policy and procedure that was implemented provides a prescriptive process. Part of this process is providing the resident/family with an information package that includes copies of all agreements signed and information about specific aspects of the program and facility that they are moving into. The process is tracked over the six week period by using a checklist/signature sheet that becomes part of the resident's permanent chart.

Tenancy Agreement

The tenancy agreement outlines all of the landlord and tenant responsibilities in relation to renting and living in the facility. All residents moving into assisted living (BC) and supportive living (AB) are required to sign a tenancy agreement. The tenancy agreement has three distinct sections: tenancy agreement, support agreement and building rules and regulations. It clearly identifies the responsibilities of the tenant and landlord including those situations that may result in a tenancy being ended.

The tenancy agreement was reviewed by legal counsel in each province and reflects the applicable legislation. Once completed the revised agreements were implemented in all assisted/supportive living programs on a go forward basis. The updated building rules and regulations were implemented for all residents by notice and provision of an updated copy.

Moving In Agreement

It was the organization's experience that over time the number of different consent forms and agreements that new residents/families were required to review and sign had become significant and confusing. The new moving in agreement incorporated the requirements of all identified forms that were being signed on admission and reduced the number of forms related to consent to two. The moving in agreement is consistent with the information that is provided in the tenancy agreement regarding resident rights and responsibilities and reasons that a resident would be required to move out. This agreement was also reviewed by legal counsel in both provinces. Once completed each resident was asked to sign the new agreement when their next scheduled care conference was completed. All previous forms that had been signed and were now incorporated in the new agreement were archived.

Moving Out Policy

This work was also completed by a workgroup that included provincial representation, all programs and relevant support groups in the organization. It addresses the policy and processes to be followed in situations where the resident is moving out.

In assisted/supportive living the reasons for moving out include resident choice or for reasons as outlined in tenancy agreement. Because the moving out may not be consensual the policy addresses both relocation and removal of residents with reference to both the tenancy agreements and moving in agreement signed by the resident/family when they moved in.

When a resident is moving out situations tend be individual and unique making it difficult to develop a prescriptive process such as was used with the moving in policy and procedure. The moving out policy addresses the need to have all involved parties in the process participate and be informed; the need to document all communication, interventions and responses related to the process; the need to complete and communicate the results of a risk assessment as regards the ongoing safety and security of residents and staff; and the need to communicate and implement any violence prevention measures identified in the risk assessment.

Occupational health and safety response and Violence prevention in the Workplace Program
Following the critical incident investigation, there was an initial sense of being overwhelmed. It began with two significant questions: where do we go from here and where do we start.

The first stage of the occupational health and safety actionable response took a considerable length of time with the starting point being a review of the literature and applicable legislation. It was also recognized that many organizations within the health sector have well established and well functioning violence prevention programs

and therefore time was invested in benchmarking with other organizations. The exploration of current best practices in healthcare and other industries in respect to violence in the workplace programs was immense.
The second stage of the occupational health and safety response was the analysis of current GSS practice and whether the existing policies complemented each other or perhaps worked against each other. Risk management policies were well established in numerous areas of the organization however historically there were not well defined linkages between staff related risk policies and resident related risk policy. It was identified that this may have contributed to the blurring the line of *"ownership"* and priority for safety investigation.
Once these two stages were completed then it was a matter of rolling up our sleeves and putting together a program which would address the provincial OHS requirements and be workable and realistic for our staff to adhere to.

An initial program draft was developed by a working group with representation from Quality Improvement/Risk Management (client/resident perspective), Human Resources, Environmental risk, and Education. The large document was vetting through numerous committees which included frontline staff, senior leadership. The draft was edited through several revisions with the final program document and all its policies being approved by the executive committee on Sept 13 2011.

This program envelopes the entire organization and as such a full implementation plan needed to be developed. This plan was created in partnership with the organization's strategic planning process and was included in two strategic directions: striving for quality and safety across the continuum of programs and the other to attract and retain staff and volunteers who are aligned and engaged. The education plan was enormous.

Mandatory sessions were and continue to be held at all sites to present the program to all staff. The major emphasis of the session and the program is that violence is not a part of your job and all incidents must be reported. Signage has been created for each site with safety emphasized as being everyone's responsibility.

The final stage of the program will be the evaluation. The program has been developed with the intent that it is a living document. As part of the evaluation process, the facilities will be required to complete an Administrative and Environmental Screening checklist biannually as well as an employee survey will be completed yearly.

Incidents related to aggressive / violent behavior will continue to be reviewed, tracked and monitored for pattern identification or if the incident has the potential to escalate risk, risk assessment tools have been developed to conduct a formal risk assessment.

Risk assessments are also a component of 'safety chats' with the employee/unit where the incident occurred. The development of interventions to mitigate risk can then be frontline based and part of working environment.

As an organization that fully subscribes to ongoing quality improvement, processes have been put in place to review the content of all policies and this program will continue to evolve over time. It has been identified that even the most prepared and anticipatory processes cannot encompass all risk nor will organizations be able to eliminate all risk. However it is the recognition that risk exists and the creation of action as a result of that recognition should never be a stagnate process. It is never easy to look within to identify areas for improvement however it is essential that we do, because without learning from incidents and taking opportunities for change as being positive, we will not truly move to a complete culture of safety.

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Learning objectives

1. An understanding of how root cause analysis is one tool that canbe used for critical incident analysis.
2. An understanding of how one organizations response to a critical incident resulted in organizational change.

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The effect of Risperidone and Olanzapine on violence against hospital staff in patients with Alzheimer disease

Poster

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Focus: Research

Abstract

Introduction

There are some doubts about therapeutic effects of the two antipsychotic drugs Olanzapine and Risperidone two antipsychotic drugs on behavioral disturbances such as violence in patients with Alzheimer's disease and concerns about safety have emerged. We assessed the effectiveness of these two atypical antipsychotic drugs in patients with Alzheimer's disease in violence against hospital ward staff.

Methods and materials

In this double-blind trial, 69 in patients with Alzheimer's disease and aggression against staff or agitation were randomly assigned to receive Olanzapine (dose, 2.5 - 7.5 mg per day) or Risperidone (dose, 0.5 - 4.5 mg per day). Patients were followed for up to 10 weeks. The main outcomes were the scores of the Clinical Global Impression of Change (CGI) scale and Brief Psychiatric Rating Scale (BPRS) and Aggression Questionnaire (AQ).

Results

Both medication decreased the violence rate. There were no significant differences among treatments with regard to improvement in Risperidone and Olanzapine group on the CGI (3.24.3 vs. 3.55.8, p=0.564) ,BPRS scale (8.29.2. vs. 8.89.2, p=0.522) and Aggression Questionnaire (AQ) (12.25.3 vs. 13.52.6, p=0.664). Furthermore, although the number of patients who had left the study cause of side effects, was greater in the Risperidone group, sedation and headache are more common with Olanzapine than Risperidone.

Conclusion

Both Risperidone and Olanzapine might be useful and reasonable treatment for patients who have violence due to Alzheimer disease in hospital setting.

Learning objectives

1. To outline the pharmacotherapy of violence.
2. To demonstrate the effectiveness of antipsychotic in management of violence of alzheimer patients in hospital setting.

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Validity and reliability of the Short-Term Assessment of Risk and Treatability in female forensic psychiatric populations

Poster

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Focus: Research

Abstract

Background

The Short-Term Assessment of Risk and Treatability (START) is a brief clinical guide for the dynamic assessment of clients risks, strengths, and treatability (Webster et al., 2004). The START is designed as a structured professional judgement guideline intended to inform evaluation of multiple-risk domains relevant to everyday psychiatric clinical practice such as: risk to others, suicide, self-harm, self-neglect, substance misuse, unauthorised leave, and victimization. One of START advantages is that it takes into account both clients strengths and their vulnerabilities in conducting risk assessment and in formulating treatment and/or management recommendations (Webster et al., 2006). Although preliminary evaluations in clinical populations have demonstrated that START has good psychometric properties (Webster et al 2004, Nicholls et al, 2006) further research regarding its reliability and validity is warranted.

Objectives

The aim of the present study is to investigate the reliability and validity of the Short-Term Assessment of Risk and Treatability (START) among female forensic psychiatric patients (N = 48).

Methods

STARTs were coded retrospectively using file review three months before release into the community on Conditional Discharge. Outcome variables included readmissions to hospital, and whether an Absolute Discharge (AD) was received in the three-year follow-up.

Results

For this study we investigated the reliability of the START using inter-item reliability and interrater reliability. For both the vulnerability items and strength items, the inter-item reliability was good, with Cronbachs alphas of .88 and .89, respectively. Mean inter-item correlation (MIC) was used to assess item homogeneity. The vulnerability MIC was .28 and the strength MIC was .27, indicating that both scales reflect a one-dimensional scale. The interrater reliability for both the strength and vulnerability scale total scores was good (N = 8; ICC =. 62, and .68). With regards to Predictive Validity, the START vulnerability total scores correlated positively with the number of readmissions (rbp= .47, $p < .001$). The strength total scores on the other hand correlated positively with AD (rbp= .35, $p < .05$), and negatively with readmission within our time frame (rp = -.29, $p < .05$). ROC analysis showed both the strength and vulnerability total scores significantly predicted readmission (AUC = .67, $p < .05$ and AUC = .78, $p < .001$ respectively). Similarly, both the strength and vulnerability total scores were significantly associated with the patient not receiving an AD (AUC = .72, $p < .05$ and AUC = .77, $p < .01$ respectively).

Discussion

Until recently clinical practice in forensic settings has been centred on a risk model, largely ignoring strengths and resilience factors in risk judgments. This study represents also an important contribution to the relatively recent body of empirical research investigating START psychometric properties. The START provides clinical practitioners with a useful tool that can help to predict success within forensic psychiatric settings and upon release from such settings through identifying gaps in services, supports, and skills as well as avenues for fostering success. Our findings suggest a balanced evaluation of clients strengths and vulnerabilities can help patients and their direct care providers to prepare for a successful transition to the community.

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Violence risk assessment and management practices in inpatient psychiatry units

Paper

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Focus: Research
Keywords: Violence, risk assessment, risk management, inpatient psychiatry

Abstract

Advances have been made in violence risk assessment and management in forensic mental health, yet it is unclear the extent to which these advances have been incorporated into daily practices of civil mental health. Some suggest that civil mental health settings are capable of successfully transferring knowledge of violence risk assessment and management into practice. While others suggest that these settings face significant challenges when attempting to do so. The purpose of this study is to survey the largest civil mental health system in Western Canada to determine what these settings are actually doing with respect to assessing and managing violence risk. Key informants from 13 inpatient psychiatry units took part in semi-structured interviews about their current risk assessment and management practices. Results suggest that few inpatient psychiatry units used established instruments for screening and assessing violence risk and many relied on unstructured professional judgment. Although inpatient psychiatry units used many strategies to manage short-term risk of violence, they reported using more restrictive management strategies that are reactive in nature rather than less restrictive management strategies that are preventative in nature. Alternatively, inpatient psychiatry units used few strategies to mange long-term risk of violence and tended to rely on communicating in general terms as opposed to making specific recommendations. The findings of this study will be used to highlight promising practices, areas for future improvement, and potential facilitators and barriers to advancing systems change in civil mental health.

Introduction

Although the vast majority of individuals with mental illness do not commit violence, serious mental illness is a major risk factor for violence. A recent meta-analysis of studies published in North America suggests that between 17% and 50% of committed psychiatric inpatients have a history of violence (Choe, Teplin, & Abram, 2008). Placing this in a broader context, research consistently demonstrates that individuals with serious mental illness are at approximately double the risk of being violent in comparison to individuals without serious mental illness (Douglas, Guy, & Hart, 2009).

Violence perpetrated by individuals with serious mental illness has major implications for victims and perpetrators, as well as the broader society. Victims of violence often suffer from physical and psychological trauma (Flannery, 1996; Gerberich et al., 2004). Perpetrators of violence may face increased stigma leading to limited access to services and decreased quality of care (Hodgins et al., 2007; Kingma, 2001). Violence results in a financial burden to criminal justice, social service, and heath systems as well as decreased productivity, increased absences and high turnover for staff when violence spills over into the workplace (Fernandes et al., 1999; Jackson, Clare, & Mannix, 2002).

Due to the potential costs associated with violence, assessing and managing violent ideation and behaviour is considered one of the core competencies for practicing clinicians (Simon & Tardiff, 2008). Mental health professionals are obliged under statutory law, common law, and professional codes of ethics to assess for and respond appropriately to signs of violence risk. Professionals who take care to recognize obvious signs of violence risk and to respond appropriately significantly decrease their exposure to legal liability.

Major advances have been made in violence risk assessment and management in forensic mental health, yet it is unclear the extent to which these advances have been incorporated into daily practices of civil mental health. Some suggest that civil mental health settings are capable of successfully transferring knowledge of violence risk assessment and management into practice (McNiel, et al., 2008). While others suggest that these settings face significant challenges when attempting to do so (Elbogen, Mercado, Scalara, & Tomkins; 2002, Higgins, Watts, Bindman, Slade & Thornicroft, 2005).

The purpose of this study is to survey the largest civil mental health system in Western Canada to determine what these settings are actually doing with respect to assessing and managing violence risk. The findings of this study will be used to highlight promising practices, areas for future improvement, and potential facilitators and barriers to systems change.

Method

Participants

This study examined the violence risk assessment and management practices of the largest civil mental health system in Western Canada, consisting of 13 inpatient psychiatry units, between July and August 2009. The number of beds per unit ranged between 4 and 100 beds (Mdn = 20 beds), the number of cases admitted ranged roughly between 34 and 887 (Mdn = 245 patients), and the average length of stay ranged between 1 and 80 days (Mdn = 12 days). Specifically, this study explored the responses of 11 key informants who represented the disciplines of nursing (64%), psychiatry (27%), and social work (9%).

Procedures

Recruitment. The medical manager and patient services coordinators of each unit in the health region was sent a letter informing them about the purpose and nature of the study, describing what their participation would involve, and requesting the participation of their unit. One week after sending the letter, the medical manager and patient services coordinator were contacted by phone to invite their unit to participate in the study and to request the participation of at least one key informant who was familiar with the violence risk assessment and management practices of their unit. Arrangements were made with each key informant identified to take part in an interview.

Measures. A semi-structured interview that was developed based on a review of the research literature and consultation with experts was conducted with key informants from each unit. The interviews lasted approximately one hour and consisted of several major sections. Specifically, key informants were asked questions related to policies and procedures concerning violence risk, screening and assessing for violence risk, practices for managing violence risk, standard communication about violence risk, and knowledge and attitudes about violence risk assessment and management.

Results

Violence Risk Assessment

All units (13) reported screening for risk of violence upon admission to their units. However, few units used a formal screening instrument (15%), while the remaining used either routine questions and observations (70%) and unstructured professional judgment (15%). See table 1 for a summary of the presence and quality of violence screening across units.

Table 1: Presence and Quality of Violence Screening and Violence Risk Assessment

Inpatient Psychiatry Unit	Violence Screening	Violence Risk Assessment
Unit 1	Y	N
Unit 2	N	N
Unit 3	?	N
Unit 4	?	N
Unit 5	?	N
Unit 6	?	N
Unit 7	Y	Y
Unit 8	?	N
Unit 9	?	N
Unit 10	?	?
Unit 11	?	N
Unit 12	N	?
Unit 13	?	?

Y = Definite Violence Screening/Violence Risk Assessment; ? = Partial Violence Screening/Violence Risk Assessment; N = No Violence Screening/Violence Risk Assessment

Alternatively, few units (4) reported conducting violence risk assessments during a patients stay on their unit. Of those, only one unit reported using a formal risk assessment instrument (8%) while the remainder (92%) reported relying on unstructured professional judgment to assess risk for violence. See table 1 for a summary of the presence and quality of violence risk assessment across units.

Violence Risk Management

Units used many strategies to manage short-term risk for violence during a patient's stay on their unit (m = 6.54 and SD = 1.45). In general, more restrictive management strategies were reported being used that tend to be reactive in nature (e.g., medication, seclusion, restraints, security), rather than less restrictive

management strategies that tend to be preventative in nature (e.g., talking, observation, object removal, reducing stimulation).

In comparison, units reported using fewer strategies to manage long-term risk for violence following a patient's stay on their unit (m = 1.92 and SD = 1.32). Most commonly units reported communicating generally about risk for violence (100%). Less commonly, units reported recommending specific management strategies for violence risk including monitoring (23%), treatment (23%), supervision (38%), and safety planning (8%).

Violence Risk Communication

With respect to mode of violence risk communication, units reported most frequently using verbal or written communication (100%) and least frequently used electronic or visual communication (8%). They were most likely to communicate with mental health professions and least likely to communicate with care providers.

With respect to content of violence risk communication, units were most likely to share information about recent history of violence and risk factors for violence and least likely to share information about recommended management strategies and general statements of the risks posed. Units did not share information about clinical formulation of violence, plausible scenarios of future violence, or specific summary judgments, all of which are considered critical components of violence risk assessment and management.

Discussion

Promising Practices and Needed Improvements

This study highlighted several promising practices and needed improvements to violence risk assessment and management in inpatient psychiatry. Promising practices some units reported using included the use of formal screening instruments, nonrestrictive management strategies, and multiple modes of communication. Needed improvements most units could benefit from included implementation of established violence risk assessment instruments, evaluation of training for prevention and management of violence risk, and development of guidelines for communication and documentation of violence risk.

Implications for Practice

Given that previous research and experience has identified potential barriers to making needed improvements to practices in inpatient psychiatry, there is a need to determine how to effectively implement violence risk assessment and management strategies into clinical practice. For instance, will systems change be most effectively accomplished through additional research and training, the development of new positions or policies, or improved leadership or political pressure?

Implications for Research

In the event that violence risk assessment and management practices are effectively implemented into inpatient psychiatry, there is a need to examine the extent to which implementation of violence risk assessment and management strategies improve clinical practice. For instance, do these practices enhance the detection and documentation of past violence, improve communication about and prediction of violence risk, and lead to better management and prevention of future violence?

Overall, the promising practices and needed improvements identified in this study have implications for establishing best practices for assessing and managing violence risk within inpatient psychiatry units specifically and across health care settings more generally. Health care settings committed to establishing best practices for assessing and managing violence risk are strongly encouraged to evaluate their own practices, to highlight the promising practices they are engaging in, and to make improvements to their practices where needed.

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Learning objectives

1. To increase knowledge of violence risk assessment and management practices currently being used by inpatient psychiatric units.
2. To increase knowledge of ways to improve violence risk assessment and management practices used by inpatient psychiatry units.

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Chapter 18 - Policy/guidance on best practice initiatives

Preventing violence in the healthcare setting

Poster

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Focus: Organisational

Abstract

Background and context

After experiencing a violent attack, a focus group of Trauma nurses started a Workplace Violence Prevention Task Force at an academic Medical Center with a Level I Trauma Center. According to the Bureau of Labor Statistics, healthcare and social services workers have the highest rate of nonfatal assault injuries in the workplace and nurses are three times more likely to experience violence than other professionals. Research suggests that violence, like many other healthcare problems, can often be prevented if approached strategically.

Methodology

The Workplace Violence Prevention Task Force recruited members of Management, Risk Management, Human Resources, Administration, Employee Assistance Program, Security, and Research to join the task force. The task force completed an assessment of the medical centers current practices, policies, and reporting procedures and developed a survey to determine the incidence of workplace violence and educational needs of nursing staff. The survey was administered electronically to nurses working in all inpatient and outpatient settings. The survey was comprised of 30 questions about experience with violence in the workplace, education on prevention, and reporting procedures.

Findings

1867 nurses completed the survey. 21.5% of staff reported prior experience with physical incidents of violence, 36.7% with verbal/emotional incidents, 14.3% with threats of physical contact and 6.3% with sexual incidents. The perpetrators of these incidents were identified as patients (27.7%), visitors (12.4%), staff members (12.6%), faculty members (3.7%) and other(2.1%). When looking at specific areas, the Emergency Department was found to have the highest number of incidents of violence. The ICU staff and the Medical/Surgical floor staff reported about the same number of incidents in each area. 39.4% of staff reported the latest incident occurred within the last year and 18.6% in the last 5 years. Factors they felt contributed to the increase in prevalence of violence included:

- Anger about a patient's condition/situation (19.3%)
- Anger about enforcement of hospital policies (17.7%)
- Cognitive dysfunction (14.5%)
- Substance abuse (12.7%)
- Workplace stress (10.9%)
- Anger related to health care system in general (10.3%)
- Anger related to wait times (9.6%)
- Other (5.9%)
- None (2.6%)

With these incidents, 10% reported being physically injured and 9% sought medical treatment. The majority of all staff knew how to report incidents, but only half actually reported the incidents. The top two reasons they did not report the incident was no injury occurred and it was a routine occurrence they were used to. All staff reported it was important to have ongoing training and preparation for dealing with violence in the workplace.

Implications for practice

Institutions should have a zero tolerance policy related to workplace violence and a reporting protocol in place. Staff should be encouraged to report incidents and have a support system available to them when an incident occurs. Ongoing education on prevention strategies and de-escalation techniques may help prepare nurses for

violence encountered in the healthcare setting. Much like the nursing process, a multidisciplinary planning approach to prevention is needed to combat violence in the healthcare setting.

Learning objectives

1. To demonstrate that a multidisciplinary approach to prevention is needed to combat violence in the healthcare setting.
2. To demonstrate that institutions should have a zero tolerance policy related to workplace violence and a reporting protocol in place.

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Workplace violence in the healthcare setting: Legislation, regulations, and accreditation approaches

Paper

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Focus: Policy
Keywords: Workplace violence, healthcare, laws, legislations, accreditation, standards

Background and context

Violence against healthcare workers is a well documented problem worldwide but regulatory strategies to combat it have not been extensively studied. Workplace violence is defined as *"violent acts, including physical assaults and threats of assault, directed toward persons at work or on duty"* (CDC /NIOSH, 1996). Violence can be classified into four types: Type I (Criminal Intent), Type II (Customer/client), Type III (Worker-on-Worker), and Type IV (Personal Relationship) (UIIPRC, 2001). This paper will focus on Type II (Customer/client) and Type III (Worker-on-Worker) which are the most prevalent types of workplace violence in healthcare.

The alarming nature of this global problem has prompted organizations such as WHO, ICN, OSHA and the ILO, to develop prevention guidelines and position statements. Yet these typically do not address how hospital accreditation processes may assist workplace violence prevention efforts. Some healthcare accreditation processes already address the work environment, disruptive clinician and patient behavior and security. Despite the complexity and severity of the problem, several initiatives have demonstrated and proved to be feasible and effective in addressing workplace violence in terms of guidelines for prevention, reporting and training in developed countries such as the US (McPhaul & Lipscomb 2004; Limpscob et al 2002; and Lipscomb et al 2006).The purpose of this paper is to review and describe existing U.S. regulatory and policy approaches toward reducing workplace violence in healthcare and examine the possible role of healthcare accreditation standards. A secondary focus is to consider the impact of such mandatory vs. voluntary approaches.

Methodology

A literature search using the CINAHL, Pub Med, Google Scholar, and Westlaw was conducted looking for workplace violence prevention laws and evidence of their effectiveness. The search also included the Joint Commission and the ANCC Magnet program standards. The rationale for reviewing these programs is that they already exist to improve safety and quality in healthcare and may be useful in the absence of state workplace violence prevention laws. The search excluded criminal statute approaches such as restraining order, injunction and enhanced penalty laws.

Findings

There is no federal mandatory standard for workplace violence prevention in the U.S. Few state have laws or regulations which require comprehensive workplace violence prevention programs. Only six U.S. states mandate a comprehensive violence prevention and reduction laws. The distinctive elements of these state laws include risk assessment, planning, documenting and reporting, training, and importantly employee involvement in the prevention and reduction of workplace violence. Joint commission and Magnet standards have certain commonalities with workplace violence prevention programs laws.

Voluntary Guidelines

In 1996, the Occupational Safety & Health Administration published *"Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers"* (U.S. Department of Labor & OSHA, 1996). These guidelines were developed in response to NIOSH's research, petitioning by unions representing health care workers, and growing awareness of the problem. The Federal OSHA guidelines were based largely on guidelines developed by California's State OSHA plan in 1993. The 1996 Federal guidelines provide an overview of the problem and a framework for addressing the problem and include the basic elements of any proactive health and safety program. The key elements of a health care violence prevention program delineated in the Federal OSHA guidelines include:

- Management Commitment and Employee Involvement,
- Worksite Analysis,
- Hazard Prevention and Control,
- Training and Education.

The 1996 OSHA guidelines were updated in 2004 and provide an outline for developing a violence prevention program, but since they are *"performance-based"*(U.S. Department of Labor & OSHA, 2004), it is up to stakeholders within the industry to do the painstaking work of implementing them in a manner that will yield results.

US State Laws

Increasingly, in the U.S. states are enacting regulations that require employers to provide workplace violence prevention programs. The US WV state laws were enacted in response to the magnitude of the problem and its associated costs, requiring that employers develop a comprehensive approach to the problem of workplace violence in high risk health care and/or public sector workplaces (Table 1). An analysis and review of these state laws compares the laws from the standpoint of employers that are covered, the features of the law, the extent to which workers and their unions must be involved and the types of workplace violence that is addressed is illustrated in Table 1.

Table 1:Summary of US States with Workplace Violence Laws

State	Date	Sector	Risk Assessment required	Employee Involvement required
New York1	2007	All Public except K-12	Yes	Yes
California2	1993	Healthcare	Yes	No
Illinois3	2008	Healthcare	Yes	No
New Jersey4	2006	Healthcare	Yes	No
Washington5	1999	Healthcare	Yes	No
Connecticut6	2011	Healthcare	Yes	Yes

1 Workplace Violence Prevention Law: Section 27-b of State Labor Law; 2 California Hospital Safety and Security Act (Assembly Bill 508); 3405 ILCS 90 Health Care Workplace Violence Prevention Act; 4 Violence Prevention in Health Care Facilities Act, Assembly Bill 3027; 5Workplace Prevention Law: Chapter 49.19 ; 6An Act Concerning Workplace Violence Prevention and Response in Health care Settings: Substitute Senate Bill No. 97Public Act No. 11-175.

Perhaps the most comprehensive US workplace violence law is the one enacted in New York State (NYS) in 2006. The law covers all public sector workplaces within the state, with the exception of K-12 schools. The Law draws heavily on the Federal OSHA Guidelines for Health Care and Social Services, originally published in 1996 and revised in 2004, requiring that employers control workplace violence via a comprehensive health and safety program. The foundation of the program is management commitment and employee involvement; risk assessment; hazard prevention and control; training and education; and recordkeeping and evaluation. Of note, the NYS law requires that the employer involve union representatives and/or other employees in key aspects of the development and implementation of the workplace violence prevention program. New York provides OSHA coverage to public sector workers through a state plan enforced by the NYS Department of Labor.

Emerging evidence suggests that comprehensive program state laws that are mandatory in nature increase the proportion of hospitals that provide workplace violence programming and are also effective in reducing assaults (Peeks-Asa, et al., 2002; Peek-Asa 2009; Lipscomb, et al., 2012).

Healthcare Accreditation Standards (Joint Commission and Magnet)
Joint commission and Magnet standards have certain commonalities with workplace violence prevention programs laws, but remain of limited use without a more explicit emphasis from the accrediting bodies. Within the US health care setting one of the oldest and largest accrediting national bodies is the Joint Commission which was founded in 1951. The Joint Commission *"seeks to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value."* The Joint Commission evaluates and accredits more than 19,000 health care organizations and programs in the United States." (Joint Commission, 2011).

The primary impetus for including accrediting bodies in this paper is that the Joint Commission has acknowledged that *"intimidating and disruptive behaviors"* among co-workers in healthcare settings can adversely affect patient care and safety. These behaviors include *"verbal outbursts and physical threats as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities."*

The Joint Commission Leadership Standard (LD.03.01.01) addresses disruptive and inappropriate behaviors in two of it elements of performance (EP) (Joint Commission, 2008).EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.EP5: Leaders create and implement a process for managing disruptive and inappropriate behaviors. In addition, the Joint Commission tackles interpersonal skills and professionalism as part of their credentialing process for physicians.

Another accrediting body that emerged in the early 1980s through the American Nurses Credentialing Center (ANCC) is the ANCC Magnet Accreditation program and commonly referred to as designation. The Magnet designation emerged through a national study the identified the hospital characteristics that were able to recruit and retain qualified nurses and maintain high quality care, despite the nursing shortage. These characteristics were later referred to as the forces of Magnetism, the 14 forces, based on which the accreditation and designation process took its official form in the early 1990s (ANCC, 2011). The 14 forces of Magnetism (ANCC, 2005) were revised in 2008 and integrated into the new Magnet model with its 5 components, transformational leadership, structural empowerment, exemplary professional practice, new knowledge, innovation, and improvement, and empirical quality results (ANCC, 2008). The ANCC Magnet Designation is a voluntary kind of accreditation, where the Magnet program recognizes nursing excellence *"in the delivery of care to patients, promoting quality health care services in an environment that supports professional nursing practice, and providing a mechanism for the dissemination of best practices in nursing services."* (ANCC, 2010). Only 6.74% (393) of all US hospitals are Magnet recognized in addition to four other facilities in four other countries (Australia, Lebanon, and Singapore). Magnet recognized organizations set the global standard for professional nursing care and innovative health care reform that fully meet the needs of patients, families and communities.

Though workplace violence is not clearly stated in the Magnet Model, co-workers relationships are depicted within the description of the exemplary professional practice component of the Magnet model where *"interdisciplinary collaboration is evident…"* Collegial working relationships within and among the disciplines are valued by the organization and its employees. Mutual respect is based on the premise that all members of the healthcare team make essential and meaningful contributions in the achievement of clinical outcomes. Conflict management strategies are in place and used effectively, when indicated." (ANCC, p.28, OOD22)

Implications and conclusion

Few U.S. States have laws or regulations mandating workplace violence prevention programs but those that exist appear to be based on the ILO and OSHA guidelines. Recent review conducted by Wassel et al (2009) examined the literature published since 1992, to determine the effectiveness of interventions in preventing workplace violence and concluded that further evaluation research is still inadequate. Lipscomb et al (2006, 2012) have been studying the feasibility and impact of a voluntary comprehensive violence prevention program for more than a decade. These projects have described the process and impacts of such voluntary efforts in high risk public sector mental health and social service settings but have noted the challenges of real world political and economic conditions that influence such voluntary efforts. Casteel et al (2009) examined the impact of the California Hospital and Security Act, assessing changes in hospital employees' violent event rates before and after enactment of the California Hospital Safety and Security Act in 1995 (Assembly Bill 508), using New Jersey a state without workplace violence legislation for hospitals and under Federal OSHA jurisdiction, as a comparison. They found that assault rates among emergency department employees decreased 48% in California post-enactment, compared with ED employee assault rates in NJ. Among psychiatric units, for-profit-controlled hospitals and hospitals located in smaller communities experienced decreased assault rates post-enactment when compared with New Jersey hospitals.

Peeks-Asa et al (2002) evaluated the impact of the California Act on security measured implemented. They relied on a 1990 California Emergency Nurses Association (ENA) survey of emergency departments (ED) in California to enumerate violent events and describe security programs and in 20000 used the Cal/ENA membership directory, to resurvey hospitals to identify changes from the original survey. Anonymous surveys were mailed to the ED nurse manager or their equivalent. The 2000 survey asked about the prevalence of violence in their emergency departments and the presence of specific security measures implemented. Overall, hospitals reported improvements in security programs. The most notable increase was in employee training, which rose from 34% to 95.6% of reporting hospitals. However, almost a quarter of hospitals reported not having general violence prevention policies, and many believed that security personnel were inadequate (Peek-Asa 2002). As part of the 2000 study, Peek-Asa compared workplace violence prevention (WVP) programs in psychiatric units and facilities in California with those in New Jersey. Information was collected through interviews, a facility walk-through, and a review of written policies and training material. Finding were equivocal, with a similar proportion of hospitals in both states having WVP training programs. They found that a higher proportion of hospitals in California had written WVP policies, and a higher proportion of NJ hospitals had implemented environmental and security modifications to reduce violence (Peek-Asa 2009).

In investigating the impact of workplace incivility (WPI) on staff nurses related to cost and productivity, Lewis and Malecha. (2011), reported that nurses working in healthy work environments(defined as (Magnet, Pathway to Excellence, and/or Beacon Unit recognition) reported lower workplace incivility scores compared with nurses working in the standard work environment.

Several studies, strongly suggest that a comprehensive and participatory approach to violence prevention in healthcare is necessary to reduce workplace violence (Lipscomb et al (2006, 2008,2012). Barish et al (2001) reviewed a number of legislative and regulatory efforts that were designed to prevent workplace violence. They also contrasted the United States with efforts in Canada, specifically British Columbia and conclude that the effectiveness of the measures adopted to date in both countries have not been adequately evaluated.

All the above suggests that the program elements: risk assessment, hazard control, training, employee involvement and report/recordkeeping are important to workplace violence prevention. Nonetheless, hospital

accrediting bodies, with their existing work environment and behavior standards are potential tools for leveraging healthcare employers to institute workplace violence prevention. Further evaluation of workplace violence laws and accreditation standards is needed to determine their impact and effectiveness for prevention and management of workplace violence in the healthcare sector.

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Learning objectives

By the end of the session participants will:

1. Be able to identify the key elements of workplace violence laws in relation to the healthcare setting
2. Be able to describe the accreditation standards in relation to workplace violence in the healthcare setting.

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Health care environments: Safety for all

Poster

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Focus: Practice

Abstract

Background and context

Healthcare has become a high stress work environment due to multiple factors, including high acuity of patients, reduced lengths of stay, complexities related to technologies, balanced with the fiscal responsibilities of ever increasing costs of care. Added to this environment, patients are often experiencing stress related to a new diagnosis and entry into hospital. They are being asked to place their lives literally in the hands of strangers. Their expectation is that the care providers will be competent, caring and will communicate professionally regarding their options for managing their health. In addition to the increasing demands from the physical environment, care providers attempt to balance family and social expectations with shift work, and weekend work. These factors have the potential to create a culture in which workers and patients may experience frustration and act inappropriately.

This work arose from a project with the Nova Scotia Department of Health and Wellness which will be the major policy practicum project towards my completion of Masters in nursing degree. In conducting a literature search regarding patient safety indicators, the context of work environment was identified as an important component of patient safety.

Methodology

Search terms were expanded to include: patient safety and incivility, rudeness, bullying; patient safety and worker safety; healthy workplace initiatives. Themes were identified which included common characteristics of patient safety culture and healthy (psychologically safe) workplaces; role of leadership in changing culture; and implications for health care policy. Various deviant/counter-productive behaviors are identified and discussed.

Focus

The focus of the poster presentation is the findings emerging from recent literature regarding the potential impact providing safe workplaces for workers has on patient safety and adverse events. The theory of planned behavior is presented as a method to implementing behavior changes which are identified as contributing to a safe work environment.

Implications for policy

The implications are presented and explored. These include (a) transformational leadership; (b) the integration of human factors and ergonomics principles and methods into systems assessments and designs of safety; (c) the need for independent verification and validation of data; (d) non-traditional sources of useful data for determining organizational or unit culture; (e) suggestions for conducting employee surveys which will provide accurate picture of an organizations culture; (f) education

Main theme

Workers and patients need the same culture of safety, which includes collaboration, teamwork, and safety as an organizational expectation. Quality is built on a foundation of safety for all.

Learning objectives

1. To review characteristics of a patient safety culture.
2. To review characteristics of a healthy (psychologically safe) work environment.
3. To discuss impact of working conditions on performance.
4. To discuss implications for policy decisions.

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A new organizational approach to managing aggression in the workplace

Poster

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Focus: Practice

Abstract

The Jewish General Hospital is a 637 beds teaching hospital affiliated to the McGill University in Montreal. As stated by Chen, Sun et al.(2009) hospitals are places where most type of violence can be observed. Episodes of violence occur regularly within the hospital context and present a risk to patients and staff. On average, 60 incidents /month of escalating violence from patients and visitors occur in our center. Until recently, it has been difficult to handle those events without causing injuries to the involved personnel or patients. Our institution therefore has decided to renew its commitment of no harm to patient or staff by reviewing and rebuilding our aggression management protocol.

In order to create a safe working area, we focused on three areas of improvement. The first step was to adopt an evidence based education program already in use in other institutions: the Omega approach. This approach was created in 1998 through a collaboration of three Qubec health institutions and the health safety organization: Robert-Giffard health center, Charlevoix health center, Douglas Hospital and the Asssociation paritaire pour la sant et la scurit du travail du secteur des affaires sociales (ASSTSAS).This approach is a combination of both theoretical and physical skills building components. The second step of the improvement plan was to create a cohesive code white team as well as provide a standardized education to all members. Facilitated by a local agreement with the union representatives, positions were opened to all beneficiary attendants. Following an extensive interview process, the positions were given to candidates having obtained the highest score d uring the interview. Expectations were set and clearly stated to each team member. Finally, to support these innovative measures, we reinstated the interdisciplinary Code White committee. This committee is interdisciplinary with representation of the Security department as well as different risk managers. Meetings are held on a monthly to discuss issues, apply corrective measures and support the code white team members. We are currently finalizing a specific protocol in partnership with the municipal police of our city to address episodes of violence involving weapons.

Following the implementation of these three measures, a significant reduction of the number of physical interventions required to address outburst or aggression was noted. Debriefing sessions have also improved communication and knowledge transfer within the members of the Code White team. Our future goals include ongoing education sessions and implementation of the Omega tools within daily practice in the psychiatry and the emergency units. Furthermore, we will implement the second phase of the Omega program which is mostly a physical component to intervene when no other way to diffuse violence episode is possible.

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How WorkSafeBC uses actuarial data to reflect risk of injury from acts of violence in healthcare

Poster

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Focus: Research

Abstract

Issue

In British Columbia, WorkSafeBC reports that 11% of all work-related injuries to health care workers that resulted in lost time from work were caused by acts of violence. Is this an accurate reflection of the risk of injury from acts of violence in the workplace?

WorkSafeBC is an employer funded agency in British Columbia, Canada that has a legal mandate to create and enforce workplace health and safety regulation, and provide health care and wage loss benefits to workers for injuries and disease caused by work activities. The dual roles of WorkSafeBC allows for injury claim information to be used for occupational health and safety purposes, including defining workplace hazards and targeting occupational health and safety resources.

However, WorkSafeBC must code employer, worker, and medical information according to standards adopted by the Association of Workers' Compensation Boards of Canada (AWCBC), and therefore, occupational health and safety requirements are not considered when coding most information. Definitions of terms are not always consistent between compensation and occupational health and safety practices.

Injuries caused by acts of violence exemplify this situation. While the coding standards adopted by AWCBC for acts of violence includes assaults, violent acts, and harassment by persons with known and unknown intent to harm, the coding practice does not capture all incidents that would be considered acts of violence in the field of occupational health and safety. Specifically, those injuries where the direct cause of the injury resulted from an action (for example, restraining an aggressive patient), or object (for example, patient hits a worker with their wheel chair) may not be coded as acts of violence, but may be coded as *"overexertion"* and *"struck by"*, respectively. In long term care these actions are often done by people with cognitive deficiencies, such as dementia.

WorkSafeBC recognized that the coding standards adopted by AWCBC did not capture all claims for acts of violence that would be considered by occupational health and safety professionals. In 1999 the organization introduced an additional coded field for cause of injury that better reflects the occupational health and safety definition of an act of violence and allows for differentiation between intentional and unintentional acts of violence.

Implications

Many health care jurisdictions rely on compensation injury data to define the risk of injury from acts of violence. Based on WorkSafeBC's experience, it is necessary to understand how injury claim information is coded, and adapt search methods, and coding practices where possible, to meet occupational health and safety requirements. This will result in a more accurate representation of risk of injury from acts of violence in the workplace, and more effective targeting of occupational health and safety resources.

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Using Interactive Theatre techniques in training to reduce verbal aggression in the workplace

Paper

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Focus: Education and Training

Introduction

Violence and aggression in many organisations including ever changing healthcare settings is a persistent problem. Historically, mental health services were the most frequently cited location for experiencing assault; this is no longer the case (Budd 1999, Wells & Bowers 2002, Bowers et al 2002, 2003, Roche et al 2010) and prevalence is wide spread in all areas of health care practice (Health Service Advisory Committee 1987, Braun et al 1991, Duffy 1995, Brennan 2001, 2003, Buback 2004, Ferns & Chojnacka 2005, Joubert et al 2005, Buettner 2006, Healthcare Commission 2007). The majority of the violence and aggression that occurs within healthcare is nonphysical (Health Service Advisory Committee 1987, RCN 2006, Healthcare Commission 2007) with verbal aggression being the most common form, considered by many as almost normative (Lanza 2006, Foster et al 2007, Ferns & Meerabeau 2008) and as a result of this, under reporting is a significant issue that clouds the picture in relation to the size and impact of the problem (Nijman 2002,). It is well documented that healthcare workers, especially nurses often view verbal aggression as 'part of the job' and are reluctant to report, complain about or even acknowledge that verbal aggression has affected them brushing it aside as a minor occurrence (Ferns & Meerabeau 2008).

A possible reason for this is a culture within healthcare environments that one should be able to cope with the demands of the job and a failure to do so can be seen as a weakness (Mckenna & Patterson 2006). The approach is often one of 'if you can't stand the heat get out of the kitchen'. A number of researchers have found this same attitude prevails even towards physical violence (Lanza 1983, Whittington & Wykes 1992, 1994).
In other workplace settings, schools and in domestic/family settings, repeated verbal aggression has been reported to result in both physical and psychological harm (Gorham & Christophel 1992, Kinney, 1994, Beatty & McCroskey 1997, Randle 2003, Steinberg et al 2003, Jayarantne et al 2004, Bekiari et al 2005, Johnson & Indvik 2006) so there is no reason to doubt the same would apply to the healthcare setting.

The emotional costs associated with verbal aggression have also been well documented and continue to be a focus within the healthcare literature (Farrell 1997, 1999, 2001, Gorham & Christophel 1992, Farrell et al 2006, Ferns & Meerabeau 2007, Sherlock 2010). It has been suggested that for some, exposure to verbal aggression can leave lasting emotional and psychological scars that interfere with the ability to function at work (Rowe & Sherlock 2005, Lanza 2006 Bonner & Mclaughlin 2007). The most common difficulties can include low self esteem, reduced confidence and in worst case scenarios recurrent and intrusive symptoms, increased arousal or avoidance (Walsh & Clarke 2003, Bonner & McLaughlin 2007). As well as the personal cost to the individual, verbal aggression has a considerable cost to healthcare organisations, in terms of management costs, staff time, staff absence/sickness, staff turnover and litigation. Flood et al (2008) suggested that the annual cost to healthcare in terms of dealing with conflict is in the region of 72.5 million pounds. Within this verbal aggression is the most expensive conflict behaviour to manage at 10 million pounds nationally.

Specific to the nursing field, research so far has focused on the prevalence, source, types, frequency, effects and consequences of verbal aggression (Cox 1987, 1991, Braun et al 1991, Farrell 1999, Rowe & Sherlock 2005, Farrell et al 2006). World wide researchers and policy makers have consistently called for 'measures' to be put in place to tackle this problem (International Labour Office 2002, National Audit Office 2003, National Institute Mental Health England 2005, Health Service Executive 2006, Health Care Commission 2007). Despite this, a lack of attention has been paid to the circumstances that precipitate verbal aggression and this has resulted in a lack of consistent approaches to training and the development of strategies for dealing with the problem. Complicating things further, a body of literature is emerging around the differences in perception of the reasons for aggression between patients and staff and also between staff themselves (Whittington 1997, 2002, Duxbury 2002, Needham et al 2002, IIkiw-Lanalle & Greyner 2003, Lowe et al 2003, Needham 2004, Jansen et al 2005,Mclaughlin et al 2010) with staff tending to view patients illness as reasons for aggression, but the ward atmosphere, along with staff attitudes when they are interacting being put forward by patients as contributory factors (Bowers et al 2011, Papadopoulos et al 2012).

Unfortunately, there has been limited attention paid to all of this detail which is surprising given that healthcare workers are believed to have direct contact on a daily basis with the victims and perpetrators of verbal aggression and the management of such behaviour is currently a high priority on mental health care agendas (National Institute Clinical Excellence 2005, Farrell & Cubit 2005, Nursing Midwifery Council 2006)but it continues to present challenges for those providing training (Needham et al 2004). The training that is provided varies in content but tends to concentrate on de-escalation and the management of physical aggression using physical intervention. These courses usually include a focus on triggers for aggression during the de-escalation stage of

the training session but there is rarely any in depth discussion or reflection on the circumstances that occur prior to the need for de-escalation (i.e. interpersonal communication) and more importantly how this can be modified.

Researchers have recently found training on violence prevention and breakaway to be lacking (Needham et al 2005, Bowers et al 2006, Rogers 2006, Dickens 2009). This is possibly due to the fact that the very basics of good communication (that we take for granted are inherent with the repertoires of all healthcare workers) are being overlooked despite the fact that interpersonal communication problems have been identified as precipitants to workplace conflict for more than two decades (Roberts 1983, Cox 1987).

Nurses and other healthcare professionals often feel ill-equipped to deal with verbal aggression from patients and colleagues (Mckenna & Patterson 2006, Nau 2007, McLaughlin et al 2010) and the low level conflict and non physical aggression that seems to exist in healthcare environments can be more of a challenge than physical aggression. Given that current training may be insufficient to get to the core of this problem, there is a need to examine and tap into strategies that can be tried and tested in order to help us intervene before situations escalate. This should include a focus on the conflict behaviors and interpersonal communications that often precipitate verbal aggression and hinder team harmony.

Training

Innovative ways to equip staff with easy to use, practical skills which they can apply in their work place settings are required but there also has to be some acknowledgement and awareness of the fact that existing communication styles are contributing to high conflict environments. We believe that in order to facilitate this awareness a number of interacting facets of thought and behavior need to be considered.

These facets include:
- the ability to be able to recognise early warning signs/understand the triggers for verbal aggression or indeed any other conflict and intervene early by adapting style,
- understand attitude and communication patterns and how they help and hinder situations,
- reflecting in the moment on intentions and perceptions,
- anticipating upset,
- understanding individual and team attitudes towards conflict and how this has an impact on incidence,
- understanding the specific coping strategies which individuals employ when experiencing conflict and how this impacts on communication style,
- understanding aspects of emotional self-regulation (coping under threat)that occur and how this all interacts to help or hinder communication,
- improving individual morale,
- considering the ward atmosphere and how this is affected by all of the above.

Training Approach

These issues cannot be easily addressed using didactic training approaches as in order for a change in attitude and behavior to occur, there needs to be some understanding of why current strategies utilised are not effective and an acceptance of the idea that alternatives are possible. These alternatives need consideration, exploration and rehearsal. Our preliminary workshops (these took place in statutory and third sector settings) had a focus on representing ideas simultaneously through text, audio, film and drawing on interactive theatre technique, this increased participants understanding of this complex information. This preliminary work has informed new ways of approaching conflict within a safe environment within our training session. A number of studies support the notion that there are positive differences in the way participants retain information gathered and applied using this forum theatre approach versus traditional modes of instruction (Race 2006, Lane & Rollnick 2008, Ramsey et al 2008, Fry et al 2009).

Interactive Theatre Techniques in Education

Interactive theatre techniques take participants on a journey of issues, behavioural choices and dilemmas. The approach allows the active exploration of intervention with a view to empowering the observer to consider alternatives. The participants can then become the characters as they negotiate their way through a ‘rehearsal for life’ in a safe atmosphere.
Aims of Interactive Theatre Techniques in Education:
- Create a safe environment that allows the participants to examine their beliefs and challenge perceptions this - can be translated into the real world of practice.
- Give the participants the chance to make informed choices to ensure they feel empowered to challenge others and their own reality.
- Create positive challenges instead of negative enforcements.
- Motivate learning by ensuring the participants experience and explore issues in a ‘real life’ context.
- Empower and inspire the participants to be active and not passive.

Design of a study to test the training intervention

This pilot study is part of a larger doctoral study to test the efficacy of interactive theatre techniques in education. The intervention is underpinned deeply in constructivist learning theory, put simply, how individuals learn

through their unique lived experiences of the world. Through establishing the outcomes on communication skills and ward atmosphere the study aims to establish whether interactive theatre is a useful strategy to aid deeper level learning. We believe that this improved communication if achievable, could have desirable effects on conflict reduction. A mixed methods design with qualitative methodology as the primary method guiding the conduct of this study was chosen as there has been a general tendency for researchers examining efficacy of training to use quantitative approaches. Some studies have used qualitative methods but there has been limited research published using mixed methods. It is anticipated this will allow descriptions of the respondents, measures of emotional, attitudinal and environmental variables which in turn can provide measurements to validate qualitative findings (Creswell 2003). Since few studies exist that link training to attitudinal, emotional and contextual changes, the use of a mixed methods approach was a logical one which would offer the researcher an illuminating and powerful view of the issue. In addition validity of the data increases when data is triangulated and derives from different sources (Cresswell 2003).

The Pilot Study

The main aim of this part of the project is to collect data on the impact of the ward based workshops on a number of measurable factors in the ward environment:

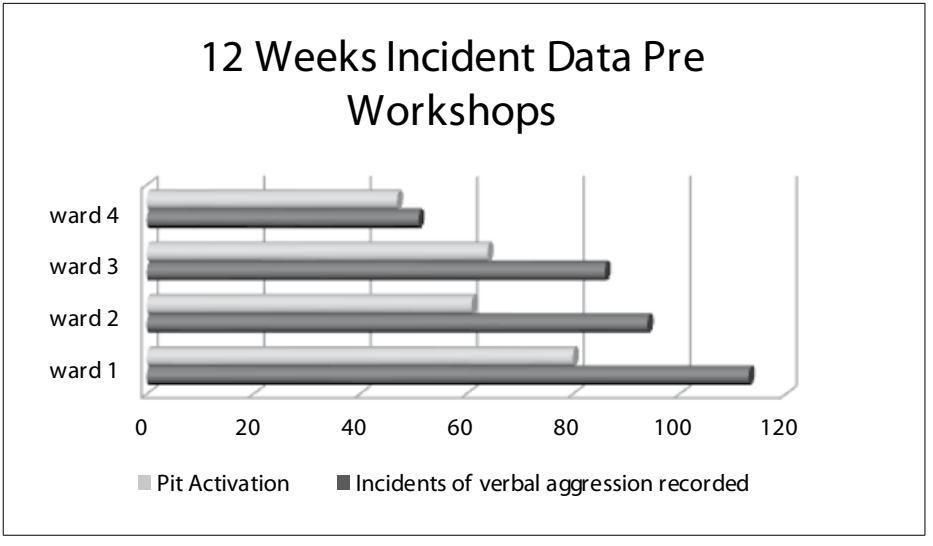
1. Patient Feedback about staff interactions and feeling safe on the ward.
2. Themes from staff communication group.
3. Ward Atmosphere.
4. PIT Alarm Activation.
5. Aggressive incident reports.

The pilot will take place in the 4 acute inpatient wards. Each participating ward will have 2 workshops. All staff will be expected to attend the three hour workshops as ward cover will be pre-arranged. This training intervention will be directed at the whole team and delivered as a group training session on the ward/practice area.

Stages in the workshop:

1. Group discussions –what causes conflicts on the ward?
2. Use of film to generate discussions about communication styles
3. Filmed scenarios (intentions/ perceptions) to be stopped and analysed, emotions and cognitions to be guessed, cause and effect to be analysed — alternative endings to be considered — what would learners do? — engaged learning, considering meaning, eliciting personal opinions
4. Live enactment of scenarios — use of interactive theatre: through a facilitator, learners encouraged to stop the action and suggest alternative strategies for characters; characters to give feedback in-role to aid insight as to cognitive and emotional processes; learners to be encouraged to replace actors in scenario to try their suggestions themselves with characters; reflection and feedback by facilitator and group. Alternative strategies to be tried as no one solution is the best in any given situation. Not over-analysed/discussed — learning is by doing, by rehearsing, which creates an unease, as an alternative method and outcome is seen, which demands putting into practice - transferable active learning.

Pre Workshop Data

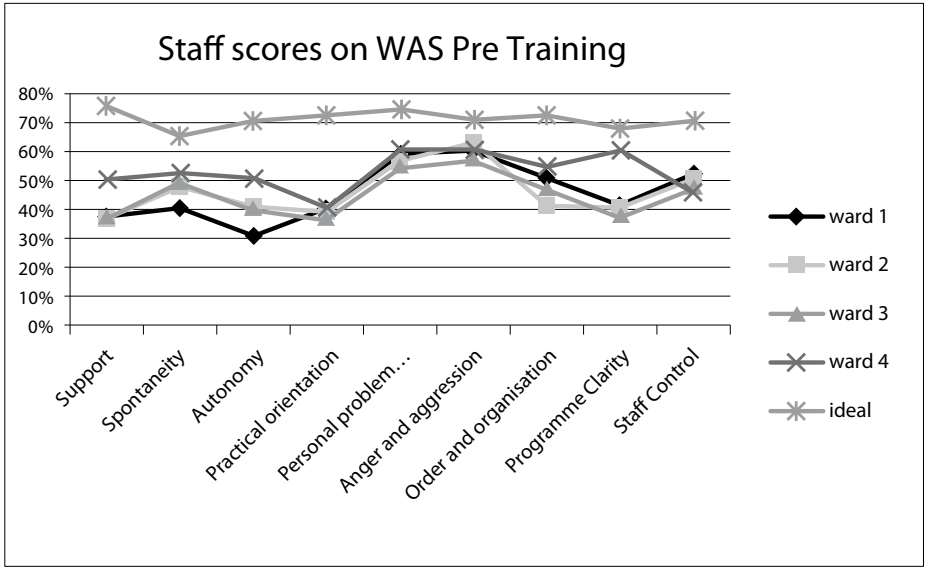


The Ward Atmosphere Scale

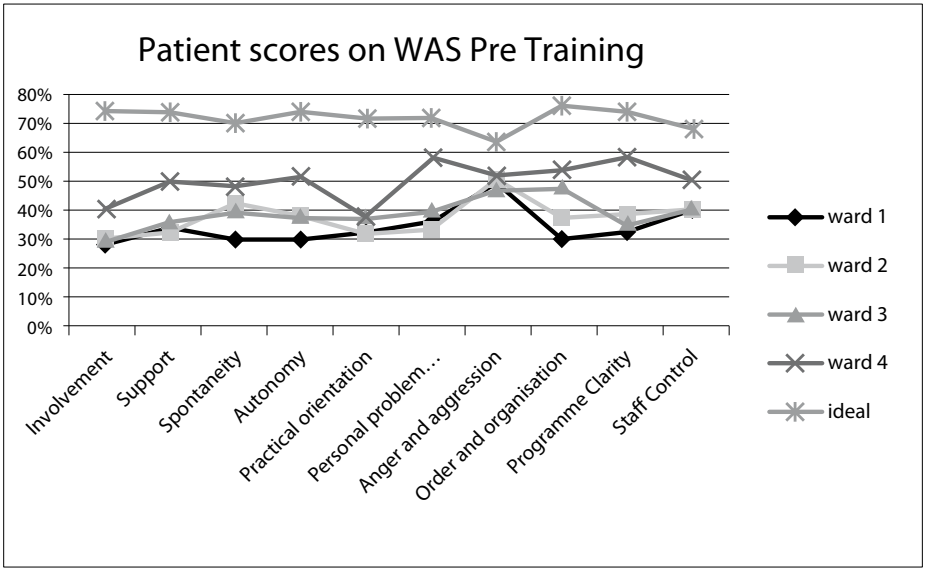
The ward atmosphere is influenced by the social structures and interpersonal interactions that occur in the environment. The work environment has been found to be crucial to the health and wellbeing of staff, patients and delivery of care (Tuvesson et al 2011). Gaining an understanding of perceptions of the working environment is important when considering the content of training programmes to improve communication, as it is very likely that the ward atmosphere will be an influential factor on how the team communicates. This information will provide details on factors that may benefit from modification within the training intervention. Moos (1997) highlights the importance of paying attention to the ward atmosphere and the impact of this upon patients and staff. He describes the ward atmosphere as a relatively stable phenomenon, the personality or social climate of the ward and describes it in terms of three dimensions:

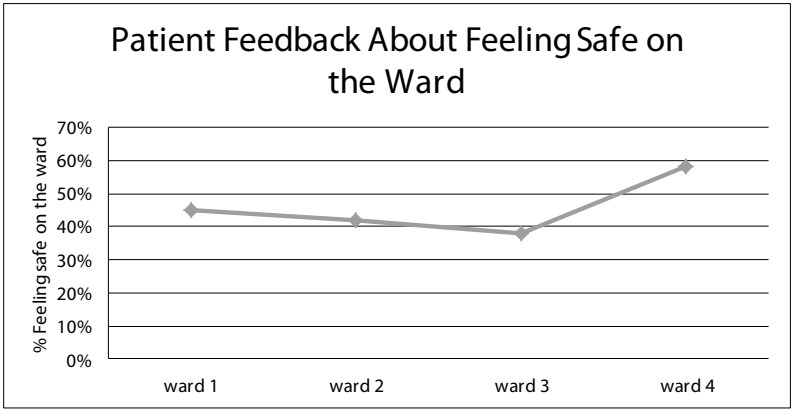
1. Relationships Dimension-the quality of personal relationships, involvement and support.
2. The Personal Growth Dimension- encouragement for personal change, patient self-development.
3. System Maintenance Dimension- order and organization of the ward.

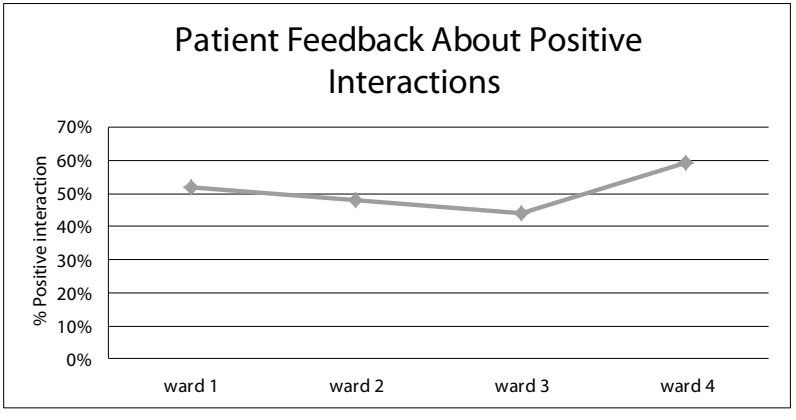
Many clinicians attribute ward atmosphere totally to the patient group but research suggests otherwise, indicating that the patient characteristics are less important contributors to atmosphere than staff, treatment policies and physical surroundings. The ward atmosphere scale (WAS) was developed to capture how the social climate operates. A number of research studies have demonstrated that ward atmosphere is important for patient satisfaction and good morale in staff. Environmental factors are known to be a significant factor in precipitating aggression (Spokes et all 2002, Bowers et al 2011) thus, paying attention to factors that can improve the ward environment and atmosphere for example interpersonal communication is important.



It was of note that even before training the ward with the higher scores on the scales for relationship dimensions and order and organization also had fewer incidents and higher scores in relation to patients having positive interactions and feeling safe.


Patient scores on WAS Pre Training
80%
70%
60%
50%
40%
30%
20%
10%
0%
Involvement
Support
Spontaneity
Autonomy
Practical orientation
Personal problem…
Anger and aggression
Order and organisation
Programme Clarity
Staff Control
ward 1
ward 2
ward 3
ward 4
ideal


Patient Feedback About Feeling Safe on the Ward
% Feeling safe on the ward
70%
60%
50%
40%
30%
20%
10%
0%
ward 1
ward 2
ward 3
ward 4


Patient Feedback About Positive Interactions
% Positive interaction
70%
60%
50%
40%
30%
20%
10%
0%
ward 1
ward 2
ward 3
ward 4

Themes from staff groups about communication
- Pre Workshops-all wards,
- Walking on eggshells,
- Keep thoughts/feelings to self,
- No point in speaking out,
- Get through the shift-survival,
- Lack of team work,
- High conflict interactions,
- Low morale,
- Lack of respect,
- Disagreements are taken personally.

Post training data will be reported on completion of the workshops.

Conclusion

Changes in healthcare environments in terms of increased staff turnover, increased patient acuity and decrease in resources contribute to the healthcare workplace being stressful work environment. Verbal aggression and conflict contribute to this and are complex phenomena that exist in the healthcare workplace worldwide. Verbal aggression and unresolved conflicts can result in negative consequences for staff and patients and are costly to the organization. Interpersonal communication has been identified as a significant precipitant to conflict, aggression and even violence but there is a lack of attention paid to this element of conflict within the training approaches we tend to rely on. There has been increasing attention paid to the cost of training and the lack of impact it seems to be having on conflict reduction, possibly due to the fact an important element of training that focuses on interpersonal communication is lacking. This paper has reported on a pilot study to test innovative training methods to improve communication. Data collected prior to the intervention has been presented and further information collected post training will be included in the final presentation.

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Learning objectives

1. Changing beliefs and attitudes about reasons for conflict and aggression can reduce prevalence.
2. Increasing knowledge of communication styles that contribute to conflict and verbal aggression can encourage reflection and bring about a change in practice.

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Workplace domestic violence: Make it our business

Workshop

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Focus: Education and Training

Abstract

Background and context

In 2005 nurse Lori Dupont was murdered on the job by a physician with whom she worked at Hotel-Dieu Grace Hospital in Windsor, Ontario and with whom she had previously ended a relationship. After he murdered Lori, he killed himself. Lori had complained to management about on-the-job harassment that started after she ended the relationship.(Carol Libby, the Windsor Star, June 15, 2010) In Canada, woman abuse in the workplace has been invisible. The tragic death of Lori Dupont has awakened us to the fact that it is a workplace issue.

Methodology

The Ontario Coroners Office conducted an inquest into the death of Lori Dupont and provided a systemic review of the circumstances surrounding her death through the Domestic Violence Death Review Committee. The inquest jury made a series of recommendations advocating training for employers and managers, safety planning for employees at risk, reporting of domestic violence in the workplace, and a review of the Occupational Health and Safety Act to examine the feasibility of including domestic violence as a factor warranting investigation and appropriate action by the Ministry of Labour. On June 15, 2010 Ontario's Occupational Health and Safety Act was amended to require employers to take reasonable precautions to protect employees from domestic violence in the workplace. The Centre for Research & Education on Violence against Women & Children used findings from the inquest and from years of research conducted by the Domestic Violence Death Review Committee to develop a workplace training program to help employers, supervisors and workers recognize, respond and refer in situations of domestic violence.

Findings

Evidence collected from friends, family members and co-workers after Ms. Duponts death revealed that there were warning signs and risk factors that, by themselves or as part of a pattern of behaviour, should have raised the possibility of danger. Recognizing them would have created opportunities to intervene and offer protection for the victim or accountability for the perpetrator. Annual Reports of the Domestic Violence Death Review Committee indicate that In almost every case of domestic homicide, people around the victim knew what was going on but did not know what to do about it. Research also shows that between 36 and 74% of employees suffering from domestic violence are victimized at work. When employers, supervisors and workers believe that domestic violence is a personal issue, not recognizing it as a workplace hazard, they can do nothing about it.

Conclusion

The Make It Our Business training program provides a variety of options to help employers recognize and respond to Domestic Violence. Andrew King of the Middlesex Hospital Alliance explains Through the implementation of this program the MHA has realized a number of benefits from our participation which include:

- Assists with the compliance of recent amendments (Bill 168) to the Occupational Health and Safety Act with respect to violence in the workplace;
- Allows the MHA to act as an example to other community partners in bringing attention to this epidemic;
- Provides information and measures for the protection of abused women, their co-workers, patients and visitors who could potentially be impacted by a domestic violence situation;
- Demonstrate to staff that we are concerned for their safety and will make every reasonable attempt possible to protect their safety.

50% structured active participant involvement: Scenario based learning actively involves participants in problem solving. Through structured rehearsals participants hone skills to recognize domestic violence and to respond effectively.

Learning objectives

1. Recognize domestic violence and its impact on victims, co-workers and the workplace environment.
2. Respond warning signs of domestic violence by communicating effectively and offering information about options for safety planning and support.

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Translational models of workplace violence in healthcare

Paper

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Focus: Education and Training
Keywords: Translational Model, workplace violence, healthcare

Introduction

There are many competing definitions and theories of workplace violence (WPV) and its components. Even those who work or do research in the field struggle to understand the numerous issues. WPV, such as threats, assaults and homicide (macro-violence), may be low in number when considering a typical workday's events, but they have high impact on individuals and the healthcare system when they occur. Lower level violence (micro-violence), such as workplace incivility (WPI), unreasonable expectations, offensive actions or words, or the lack of action or words need to be better understood as possible antecedents of macro violence.

Since micro violence is more frequent than macro violence, primary prevention and perivention becomes a relevant opportunity in our daily work. Periventions are defined as timing and location interventions that would occur right before, during, and right after a potential or real violent event occurs (Privitera 2011).

Violence from patients, visitors and family, staff styles of interaction as well as organizational contributions to violence (Bowie 2011) are often socially and politically delicate to discuss. This may be due to numerous competing interests, vantage points and agendas involved (Tabone et al, 2011). Staff may fear they will be blamed and loose their job and tend to under-report incidents.

Translational science refers to a highly collaborative process of the translation of basic research findings more rapidly and efficiently into practice. It is multidisciplinary by nature. Translational models in WPV then, would help translate a wealth of basic research in WPV in ways that would be more understandable and thereby more usable across a broad array of disciplines and professionals. The goal would be to help multiple disciplines and professions converge on common understandings in the complexity of violence and its causes. The goal of using translational models would be to reduce the interprofessional communication, procedure and jargon differences that interfere with effective solutions (*"Tower of Babel"* phenomenon - Michalski and Privitera 2011).

Sharing information that conceptually joins micro violence with the potential for macro violence outcome may align efforts across disciplines and professions for more coordinated and sustained impact. Micro violence can generate from individuals and organizations.

Methodology

Translational models were designed to summarize and integrate major contributing factors to violence in order to more succinctly convey such concepts to organizational decision makers. The authors will present translational visual models to reduce excessive jargon and more clearly convey concepts which illustrate how WPV concepts may relate to each other. Relevant basic science and clinical science research will be used to construct derived concepts into these models.

Findings

- There is a need to integrate the many existing pieces of research and clinical concepts of WPV in actionably useful ways.
- Excessive intraprofessional jargon and procedural difference impedes the interprofessional communication needed to work on WPV problems together.

Much of the literature on workplace violence, for quality and reliability of scientific findings, focuses upon specific narrow realms of study that can control select variables. Though scientifically sound, their scope of application may be too narrow to be operationally applied. Other sources of findings might be derived from anecdotal reports and expert opinions. Three major realms of study in WPV include: 1) Substrate (the person), 2) the stimulus, and 3) the environment in which these exist.

Often, violence may come in a healthcare setting, fairly rapidly. Having an approach to more rapidly assess the escalating event requires and ability to synthesize the individual roles and interaction of these three realms. Models are necessary for ease of conveyance of concept.

1) **Person.** The tendency to violence can be envisioned along a spectrum from high risk to low risk individual.

a. In the high risk range, there are a number of contributing factors:
   i. Aggression in an antisocial personality disordered individual that is instrumental, having a specific goal in mind.
   ii. Medical and psychiatric conditions that alter the person's thinking due to illness that make their perceptions altered, e.g., delirium from medical causes, drugs, psychosis with paranoid delusions etc.
   iii. Aggression triggered by past history of violence, PTSD
   iv. Reactive aggression, e.g. in Borderline Personality disorder.- with emotional sensitivity/ dysregulation (Siever)
b. In the low range we might consider the average individual's risk. The concept of *"the man on the Clapham omnibus"* - a hypothetical reasonable person used by English courts where it is necessary to decide whether a party has acted in the way that a reasonable person should. For example, this may be used in a civil action for negligence*. Using this concept and judging behavior against such a reasonable person, we may now acknowledge and account for types of stimuli and/ or environments that may raise the odds for violence if the situation were dire enough. This concept opens the door to discussions that include organizational and interpersonal contributions to violence.

The reasonable person concept becomes even more salient within healthcare settings, where self sacrifice and self effacement is taught in professional schools to healthcare staff. Recognition of when self sacrifice and self effacement have reached their reasonable limit is a dilemma to decipher both internally and external to the individual.

Incrementalism is a process by which small additive changes in procedures, regulation or policy from multiple sources can accumulate unbeknownst to the staff or administration. Increasing expectations on healthcare staff due to well-meaning regulations, law, political pressure, and insurance methods to lower usage of patient benefits add up to unreasonable levels. Yet, there exist no central *"clearing house"* to manage how far these expectations on staff should go.

Their sources are multiple. Expectations on healthcare staff in the cause of quality of care are not coordinated by any single entity, and each source has authoritative capital. Because the changes are incremental, their additive enormity occurs below detection and awareness, but raising the stress and coping challenges to individual staff. Reduced resilience to patient demands, less demonstration of compassion to patient needs results. This creates a negative experience for the patient on quality of care, at the point they need it the most (pain, fear of their disease, etc).

2) **Stimulus.** The proclivity to induce violence can be envisioned along a spectrum from high range to low range stimuli
   a. In the high range stimulus, highly noxious stimuli may exist that is likely to provoke a violent response, aggressive act that may require self protection, incivility mid range, to the low end of a benign statement that can be misperceived to no stimulus at all.

3) **Environment.** Is the environment a protective factor to the interaction of person and stimulus to a macro violent outcome, or might it be an aggravating factor to the interaction of person and stimulus to a macro violent outcome? In this realm, organizational culture and philosophy can influence the outcome of interactions between persons and stimuli. Organizational and milieu contributions to violence are often ignored when much of the literature focuses on dyadic relationships involved in dispute, failing to capture the systemic environment.

A review of the violence theory literature was done to examine mechanisms of how smaller stimuli may progress to macro violence. A number of relevant theories were obtained. Those that relate to additive effects of stressors are The Frustration-aggression Hypothesis (Dollard 1939, Brennan 1998,); The Negative Affect Escape Model (Baron and Bell 1976,); and Excitation-Transfer Theory (Zillmann 1988). All of these theories would take into account the environment of the individual(s) involved, and help us to make sense of the mechanisms of environmental contribution to violence.

The Frustration-aggression Hypothesis: aggression presupposes frustration, inability to achieve an intended goal. Frustration produces a potential for a number of different responses, only one of which is aggression.

The Negative Affect Escape Model postulates that increasing heat (as example of aversive stimulus) increases aggression when total negative affect experienced is in the low to moderate range (the fight response), but excessive heat decreases aggression when total negative affect gets too high (flight response).
Whether fight or flight response occurs depends on a number of factors that include how the person examines and controls feelings, and how they analyze the situation.

Environmental stressors
Arousal: hot, noisy or crowded places can raise physiological arousal.

Cognitive overload: If we receive too much stimulation/information from an environment we may not be able to think or function as well.
These can be from well intended regulatory requirements, or electronic medical record complexities (*"friendly fire"*).

These also come from profit-intended obstructions to patient care. Examples include purposeful hassle of clinicians (or patients) in their attempt to get needed care for patients, actually designed to wear them down by lengthy paperwork, frustrating phone procedures, often without a human at the end of the phone, hidden criteria for coverage, and other sinister procedures. Frank conflict of interest procedures in insurance companies in the guise of *"cost control"*, giving bonuses to health insurance staff for denial of care to patients, etc (*"enemy fire"*).

Behavior interference: Noise or physical layout of an environment can frustrate our behavior

Negative affect: an unpleasant situation can put us in a bad mood

Excitation-Transfer Theory

Schachter claimed that emotional arousal is nonspecific, and the individual cognitively assess the emotion he is experiencing Excitation-transfer theory is based on the assumption that excitation responses are, for the most part, ambiguous and are differentiated only by what emotions the brain assigns to them. Zillmann adopted and modified Schacter's view on this:"residual excitation from essentially any excited emotional reaction is capable of intensifying any other excited emotional reaction". Hence patient arousal from pain, frustration with obtaining care, etc may be a contribution to their aggression toward staff. Staff struggling with many aforementioned barriers to their care of patients, overloaded work assignments in staff cutbacks, etc, arouse staff which then can contribute to incivility or aggression toward patients or other staff.

Violence infliction

Four modes of violence infliction (World Health Organization)

- Sexual
- Physical
- Psychological
- Deprivation

Law and ethics help define the bounds of sexual and physical violence. However the extent of psychological impact and deprivation can be individual in source,
acute or delayed in manifestation, and sometimes diffused and harder to trace back to the responsible source as they can be inflicted in forms of collective violence (Social, Political and Economic methods of violence).

Implications and conclusions

A more systemically informed approach to regulation, law and policy is needed in health organizations and the external agencies that affect their ability to care for patients. Examples: State law that protects an individual patient's rights requiring a judge to authorize medications over the patient's objection, may greatly affect the safety of other patients and staff if swift legal resolution is not made available. Hospital and regulatory quality improvement procedures that are reactive to adverse events may collect over time, layering policies and regulations that may loose sight of the larger systems picture they intended to improve. The resultant chaotic impact on clinician work-flow are organizational contributions for violence to occur.

By translating concepts and language that had been unique to the many professionals that make up healthcare service systems or legal and law enforcement professions, professionals will be able to talk with each other with common conceptualization of the problem of WPV in healthcare, increasing the chance of sustainable solutions.

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Learning objectives

1. There is a need to integrate the many existing pieces of research and concepts of WPV.
2. Excessive intraprofessional jargon impedes the interprofessional communication needed to work on WPV problems together.

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Actors and triggers in workplace violence and their organizational environment: An integrative model

Poster

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Focus: Education and Training

Abstract

A range of Biopsychosocial theories have been used to explain workplace violence (WPV) behavior. Such cross professional contexts may in turn colour how these terms are understood by others from different professions Many such theories have been generated from experience and observation by practitioners across a wide range of professional contexts. However there is a danger that concepts believed to be common across many professions may be misunderstood or not utilized due to jargon limitations This is referred to as the Tower of Babel effect (Michalski and Privitera 2011). Thus translational visual models built from this collection of Biopsychosocial theories of violence will be useful in assisting the interprofessional cooperation needed to lessen WPV.

Healthy organizational work environments may be moderators of the expression of the interaction between potential perpetrator (actor) and the aggravating stimulus. More analysis of these potential moderating factors in the organization merit analysis for recognition and management. If violence is defined as an act by one or more persons that in some way harms another (Bruce 1999), harm then must include injury to a persons body, emotions or spirit. Looking for ways to positively affect the moderating factors of organizational work environment requires better identification of negative affects on the organizational health.

The visualization is that of an iceberg, with the iceberg above the water line being macro violence (threats, assaults or homicide). The iceberg below the water line is micro violence (e.g incivility, passive or active aggressive behavior, etc). Below the water line, our model first illustrates a range in the spectrum of tendency toward violence in the individual actor interacting with the spectrum of degree of noxiousness of stimuli. An inverse relationship is demonstrated in this interaction: lower stimulus needed in high risk individual, higher stimulus needed in low risk individual.

The healthcares organizational health is represented by the water level (more is more health, less is less health i.e. organizational contributions to violence). Organizational health is then the antonym of organizational contributions to WPV. Two separate representations of this model vary by water level; i.e., normal water level, normal organizational health some micro violence may be converted to macro violence. This violence would represent that micro to macro conversion which may be beyond the influence of organizational health. Low water level, poor organizational health (organizational contributions to WPV) more micro violence may be converted to macro violence, demonstrated by more iceberg above the water line.

Better characterization of the water component (organizational health) is necessary. Illustrating well intended organizational quality improvement processes that have gone awry to toxic processes will be termed friendly fire for ease of classification by intent. Management and business processes that began as legal and ethical, but are purposely and obscurely manipulated for purposes of greed or power will be termed enemy fire. Both of these terms were meant to imply the inherent toxicity and hence violent impact, but are differentiated by intent. These two representations would be visually smaller on the poster, and would elaborate more on organizational issues that compound or mitigate the individual/noxious stimuli interaction first referenced above.

Compiling numerous dyadic interpersonal violence theory literature and spectrums of risk for violence was used to assemble the perpetrator/ stimulus portion of poster (Ferns 2007, Mendes 2009, and Siever 2008). Examination of literature on organizational contributions to workplace violence helped to assemble the concept of water level (Bowie 2011, Privitera, Bowie 2011, Cotton and Hart 2003, Andersson and Pearson 1999). Ways to visually integrate the interaction of these related processes was the product of this work:

- Integrating organizational health effect on dyadic theories of interpersonal violence allows more rapid understanding by individuals clinically or administratively needing to understand these relationships.
- Classifying well intended processes that go awry as causing violence allows us to better understand downstream impact that paradoxically makes the healthcare environment a more violent culture.
- Classifying legally and ethically acceptable processes in resource management as metamorphing into malignant, violent processes by deception and obscurity as enemy fire. These processes also make the healthcare environment a more violent culture.

By identifying by naming these potentially reversible processes, understanding downstream potentially violent impact, we may more effectively eliminate them from the organizational culture. Improving the health of the healthcare ward environment (Arnetz and Arnetz 2001) we may reduce the risk of WPV, and possibly modelling a less violent world to the community (Bruce 1999).

Learning objectives

1. Integrating organizational health effect on dyadic theories of interpersonal violence allows more rapid understanding by individuals clinically or administratively needing to understand these relationships.
2. Classifying well intended processes that go awry (‘friendly fire’) and legally and ethically acceptable processes in resource management that get purposely manipulated into malignant, toxic processes by deception and obscurity (‘enemy fire), we may more quickly identify organizational contributions that impact workplace violence.

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Hospital policies on workplace violence: A discourse analysis

Paper

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Focus: Policy

Abstract

For many nurses, violence has long been considered just part of the job, but the level of violence in the hospital workplace is increasing, especially in the U.S. despite the fact that workplace violence in general in the U.S. has been falling since 1994. Four World Health Organization reports on workplace violence prevention programs addressed common aspects of workplace violence prevention programs in many different countries, providing model policies, evaluation instruments and form letters. The number of Medline articles on workplace violence has gone from none in 1970-1974 to 193 in 2000-2004 and 547 on January 11, 2012. The human costs of workplace violence in the hospital are high, including both physical injuries and psychological effects. Policies in acute care hospitals reflect the concern with escalating violent incidents. As a related body of documents with effects on power relationships, hospital policies are a good candidate for a discourse analysis. I will p resent the results of a discourse analysis of acute care hospital policies regarding violence in the facility from selected medical hospitals, not psychiatric hospitals, in Canada, the U.S. (including the nation-wide Veterans Affairs hospitals and U.S. territories), the U.K., Australia, and Norway. The dominant discourse of hospital policies is risk management. Two resistance discourses were identified, the discourse of patient rights and the discourse of professional ethics. The effects of these discourses on power relations will be discussed.

Learning objectives

1. Hospital policies with regard to violence are developed by managers, not health professionals.
2. These policies have direct and indirect effects on power relations among hospital employees, patients and health professionals.

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Violence against medical doctors: The role of the healthcare establishment

Paper

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Focus: Policy
Keywords: Violence, medical doctor, legal protection, punishing policy, zero tolerance

Introduction and background

Violence towards health care workers and physicians in particular is absolutely unacceptable, both from the standpoint of the health care service users – the patients, as well as from the standpoint of the health care systems in general .Violence is, however, an urgent problem in many countries in the world. It begins with a verbal abuse, and may escalate into very serious injury and even lead to the death of the victim.

The definition of violence by the European Commission is as follows: Violence in the workplace is any incident including the staff members to be abused, threatened or attacked in circumstances related to their work, which explicitly or implicitly affects their safety, welfare or health (Elston 2002)). The definition of violence against doctors involves any intentional use of force - threatening or actual – against another person or a group connected with the work circumstances that may cause an injury, or if there is a high degree of probability that it will result in an injury, death, psychological damage, degradation or loss.

Violence in the health care sector diminishes the quality of the working environment of the health care professionals it compromises the health care system and, ultimately, impairs the health care quality. Violence in this area has thus a human, economic and professional application.

Causes of violence against doctors

Many causes of violence against doctors exist including the following:

- Deficiencies in the doctor-patient communication. The doctor is obliged to tell the truth to the patient and his or her relatives about the seriousness of his or her health condition;
- The medical profession is poorly presented in the media. Negative media reports about the connection between doctors and corruption and reports of fraudulent conduct creates the ill impression that, sometimes, makes patients to see the doctors as their enemies. By this mechanism doctors may even be stigmatized;
- This can lead to torture, harassment, raids on homes, telephone harassment, verbal assaults, beatings and even the murders of the doctors;
- The lack of response from the justice system Often, the police do not react at all to claims of victimization of doctors by patients and often trials last too long:
- The patients' awareness of the probability of getting away with impunity for harassing doctors;
- The lack of the security for the doctors;
- The absence of laws that protect the doctors: one does not attack a police officer nor a bus driver on duty, as they are so-called officers.

Such laws exist solely in Finland and Israel. The Knesset in Israel proposed a law that punishes the perpetrators of violence towards the healthcare workers by imprisonment for five years instead of the three years as it used to be. The main goal of the application of this law is to minimize the level of tolerance towards zero tolerance in such situations. This way persons attacking and harming medical teams or damaging the equipment are warned that they will not to be able to receive any medical treatment in the institution they perpetrated their aggression. Persons repeating violence are prevented to receive medical treatment within three to six months, except in emergencies.

It is necessary to work harder on developing a strategy to create a safe working environment for health care professionals and – consequently – improve the quality of medical treatment for the patients. According to the World Health Organization, more than a half of all workers in the health care sector may experience a violent incident. The International Labor Organization was the first to draw attention to this in the seventies. In Australia, half of all the doctors were assaulted at least once during service.

16.2 percent from 1000 Indian physicians experience violence annually (Madhok 2009). The attacks on doctors reach pandemic proportions.

The high level of violent acts against health care workers are caused by the lack of organized activities supporting the health care facilities and its employees, the lack of political will to resolve this problem as well as the avoidance of the political elite to pass laws that would protect the health care workers by the government. Governments around the world are expected to express an unreserved condemnation of all the forms of violence.

Violence against doctors in Serbia is present more than it is talked about. Doctors are being attacked by patients or their family members in almost all health care settings with doctors being abused in primary-care units, clinics, hospitals, admission wards, emergency rooms and even in the offices of the Federal Health Insurance. A recent response to violence against doctors was, a campaign entitled *"Health is spread by a smile"* which – unfortunately only increased the frequency of attacks on the doctors in Serbia. Our own study partly explores the connection between judicial attitudes regarding the physicians being the victims of violence that are very far from the principle of the zero tolerance for violence against doctors.

Discussion and conclusion

The Serbian Medical Chamber, as a National Medical Association, proposes to solve this problem by proposing a special law for the medical profession that would define a clear mechanism of legal protection of physicians from acts of violence. Special attention should be focused on the criminal policy against the offenders.

The solution to the increasing problem of violence against the doctors in the Serbian health care system lies in the recognition of the phenomenon by the health care establishment. Therefore, it demands joint action of all stakeholders of the health system against the violence. Solid cooperation between the governments, the medical chambers, the health care institutions, the insurance companies, police and judiciary is necessary. Other strategies include the provision of better protective and safety measures, the doctor's authority to transfer offenders to other physicians or institutions, the establishment of a protocol of behavior, the recording of violent incidents at the national level, and specialized training of physicians to recognize possible offenders. Finally, it is necessary that doctors receive the status of an official in Serbia.

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Learning objectives

1. Participants will learn about the mechanism of legal protection of medical doctors.
2. Participants will learn about anti-violence actions.

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Development of an alert system for identifying potential violent and aggressive behaviour in residential care

Paper

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Focus: Organisational

Abstract

Background and context

An Alert protocol for identifying the potential for violent or aggressive behaviour in residential care clients has been accepted by stakeholders and will go to trial in the spring of 2012 within the Vancouver Coastal Health Authority (VCH). The obvious benefit to such a protocol is that client behaviour can be better managed and incidents prevented when the potential is known.

Methodology

A working group, mostly of clinicians, began with a literature search and knowledge of a similar Alert protocol recently introduced into the acute care facilities of VCH. A variety of residential care practices were already in place to address the risk of violence and aggression, but nothing consistent or comprehensive across the various sites and, especially, not easily available to caregivers. A process and information flow diagram was developed to enable an understanding of the process from the time a client is identified as needing a residency placement until their discharge. While it had been hoped that the residential Alert protocol could essentially mirror the acute protocol for consistency and flow-through effects, this proved not to be the case. The working group participants disagreed with the behaviour terminology used in the acute facilities. They were adamant that the term violent was not appropriate to describe their clients. They also made it clear that the Alert process should not duplicate work and take advantage of client information already collected using Minimum Data Set 2.0 (MDS). MDS is an electronic tool that provides a standardized approach to assessing the health, functional and psychosocial needs and strengths of a client. The quest became how to develop a protocol that aligned with the acute facilities, while respecting the culture and other sensitivities of the residential environment.

Findings

Several factors helped to make the outcome a success to date. Working group members saw real value in developing an Alert protocol that worked for all sites and their interest led to good discussions and problem solving. The Minimum Data Set 2.0 (MDS) already being collected led to a solution for resolving the issues around terminology. Instead of wrangling over what specific behavioural indicators constituted violence versus aggression, the MDS behavioural indicators themselves (as well as another internally developed risk screen) were used to determine whether an Alert protocol should be initiated. The culture issue disappeared with this approach. The process and information flow diagram formed the basis of what the best information gathering points were, and led the group to determine what was already being done well and where gaps needed to be filled.

Implications for practice

The process followed and lessons learned during the development of a residential care Alert system may serve as a model for Alert systems in other residential settings. The residential Alert tool itself is innovative because it supports and incorporates current clinical practice, and provides direction and guidance to staff to focus on preventive interventions e.g. behavioural care planning.

Learning objectives

1. The cultural differences in the perception of violence and aggression in residential and acute care can be addressed by focussing on behavioural indicators instead of terminology.
2. A successful residential Alert system should incorporate existing clinical practices and focus on preventive interventions.

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Breaking down the barriers - reducing the risk of injury to care workers by sharing information

Paper

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Focus: Policy

Abstract

Background

In 2008, Workplace Health and Safety (WHS) professionals within the Interior Health Authority (IH) developed an electronic aggressive behaviour alert system which notifies staff that a patient/client/resident had a history of violent behaviour or demonstrated risk factors for violence. This initiative was deemed a priority by WH&S due to following factors: the increase in staff injuries resulting from aggressive patient behaviour, IH's legal obligation to inform their workers of personal safety risks in the workplace and the health authorities received specific direction from the British Columbia (BC) Ministry of Health to focus on a Violence Prevention Strategies and Article 32.03 of the 2006 BC Nursing Collective Agreement which stated When the Employer is aware that a patient/resident/client has a history of violent behaviour, the employer shall make such information available to the employee. Due to the perception that applying an aggressive alert may be in violation to a patients right to privacy and that labelling a patient as being aggressive may have a negative impact on subsequent care provided, the Interior Health Senior Executive Team requested the aggressive alert process be thoroughly reviewed and endorsed by the Quality Improvement and Patient Safety Counsel (QUIPS) and the IH Clinical Ethics Committee (IHCEC) before they would approve implementation of this alert process. Finding a balance between patients rights, and the legal obligations to inform staff of risk in their workplace proved difficult for both these bodies. It soon became apparent that a thorough review of existing privacy and safety laws, legislation and acts was required to gain a better understanding of how to appropriately share patient information when a risk to others was at stake. In consulting other health authorities, it was also evident that they were all facing this same dilemma.

Results

The province of BC has no legislation that solely covers the collection and use of health records. To determine the appropriate and legal use of patient information, a number of sources need to be considered. The legislation that drives the need for information sharing is BCs Occupational Health and Safety Regulation, enacted under the Workers Compensation Act. It requires that employers must inform workers who may be exposed to the risk of violence of the nature and extent of the risk which includes a duty to provide information related to the risk of violence from persons who have a history of violent behaviour and whom workers are likely to encounter in the course of their work.

The legislation that governs the collection and use of personal information by public bodies in BC is the Freedom of Information and Protection of Privacy Act (FIPPA). This legislation is widely quoted as the reason to prevent patient information from being shared, even though the Act has clear provisions stating that information can be used to protect the health and safety of any person. The Office of the Information and Privacy Commissioner has previously established a test to determine the proper use of information: the right information, to the right person, for the right reasons, at the right time.

Most direct care workers are unaware of the details of FIPPA, and are more influenced by their professional codes of practice. Under the Health Professions Act (2003), twenty-three self-regulating colleges were created, each with its own codes of practice, conduct or ethics. All but one allows for reasonable use of a patients personal information when there is a risk to the safety of the patient or another person. As there remains significant concern throughout the care system about the damaging effects of labelling patients, when there is doubt about whether or not to share patient information, care professionals err on the side of caution, and do not use the information appropriately.

There have been a number of high profile incidents of violence against care workers in British Columbia in the past few years. A common theme from the investigations conducted into the cause of the incidents showed that although information was known within the various organizations, it was not used in a way that would minimize the risk of violent behaviour to direct care providers.

The fundamental question raised by this dichotomy is If you don't know a hazard exists, how can you prevent a worker from being injured?

Impact on this Information on Interior Health's Aggressive Alert Implementation

Having a clear understanding of the BC Occupational Health and Safety Regulations, the FIPPA legislation, the Office of the Information and Privacy Commissioner recommendations and the various Health Professional Acts

enabled the two IH endorsement bodies (QUIPS and IHCEC) to recommend to senior leadership that they approve the implementation of the Aggressive Alert Process. They emphasized that the alert process struck a reasonable balance between a patients right to privacy and staffs right to a safe workplace. Without this consolidated approach, the implementation of this alert process may have been delayed indefinitely.

Further Dissemination of this Information

With the implementation of the aggressive alert system at Interior Health, the next step was to bring this discussion to the greater audience throughout the province. Advice was sought from WorkSafeBCs Freedom of Information office, which made three significant recommendations. The first was to limit information strictly to violence prevention (proper use of patient information also has implications for infectious disease and musculoskeletal injury prevention). The second recommendation was to clearly indicate that the information being provided did not meet the standard of legal advice. The final piece of advice was to not prescribe a solution to this issue, but to point out the various facets of the issue, and encourage organizations to develop their own information sharing policies that met their specific situation and needs.

To ensure that patient information is being used for the intended purpose of maintaining worker safety, a two question test was developed:

- Is disclosing this information necessary to protect this workers (or anyone else's) safety?
- Will disclosing this information lead to changes in work practices to reduce the risk of injury?

If the answer to these questions is yes, then some level of information needs to be communicated to the direct care providers. A draft bulletin was circulated to over 30 organizations, including health authorities, unions, professional colleges, post-secondary schools, employer organizations, safety inspectors, the Ministry of Health, security professionals, and occupational health & safety professionals for feedback. Twenty-three pieces of feedback were received.

In June, 2011 a WorkSafeBC bulletin Communicate patient information: Prevent violence-related injuries to health care and social services workers was released. The impact of this simple bulletin has been broad. It has been worked into health and safety training courses; it has been used to change policy in one health authority, and influenced policy change in others.

Conclusion

This process showed that there is much common ground between the specialties of occupational health and safety and clinical care. The goals of safe workplaces and quality patient care are not mutually exclusive. Informing the policy making process helped remove some of the mythical status given to patient confidentiality. This will allow patient information, which is appropriately shared for clinical decisions, to be used in a similar manner to protect workers from injury.

Future provincial activities will focus on the promotion of awareness, dialogue and encouragement of improved policies by health employers and health colleges (including private health care providers who are governed by different privacy legislation). A future challenge will be when British Columbia moves towards a centralized electronic medical records system, which may result in the creation of a single piece of legislation covering all aspects of patients health records.

Learning objectives

1. Myths around the limits of patient confidentiality can put workers at unnecessary risk from violent behaviours.
2. Providing policy makers with an understanding of their various legal obligations can lead to solutions that satisfy the need to protect patient confidentiality and worker safety.

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Staff approach to decreasing violence in nursing homes: An innovative best practice in San Francisco

Poster

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Focus: Practice

Background and context

Historically emotional, psychological, and behavioral problems are prevalent in nursing home settings, difficult for staff to treat, and often limit discharge options. Researchers have noted the benefits of non-pharmacological interventions and discussed the importance of social contact and structured activities in treating long-term care residents with severe mental illness resulting in aggression and violence. Research has also documented the benefits of collaborative team approaches, for both the care recipients (i.e. improved outcomes, more effective use of health resources) and providers (i.e., superior morale, coordination, and problem-solving).

Methodology

After a five year review of patient and provider data at the San Francisco Veterans Administration Medical Center (SFVAMC) a negative relationship was discovered between an increase of staff team meetings, prevalence of aggression/violence, suicidal ideation, and homicidal ideation. As a result, the SFVAMC launched an innovative and effective program called the Social Focus Cohort (SFC). The SFC is located in SFVAMC's Community Living Center (CLC), which is a 120 bed short- and long-term skilled nursing facility caring for primarily male patients ranging from ages 20-100, many of whom have been diagnosed with severe mental illness resulting in aggression and violence. The SFC Team addresses complex problem behaviors by restructuring systems, implementing environmental interventions, creating a specialized team approach and increasing education/training. Since its inception, the SFC has received numerous awards substantiating it as best practice for providing care to residents with severe mental illness.

Findings

The general purpose of the SFC is to provide specialized interdisciplinary expertise, comprehensive milieu-based therapy, and psychological/behavioral management. The SFC Team utilizes multiple disciplines including geroto-psychologists, medical providers, social worker, recreational therapists, occupational therapists, and all levels of nursing to assist residents in achieving the highest possible level of psychological, behavioral, cognitive, and social functioning within the least restrictive environment. As a result the following treatment outcomes were achieved: lessening of symptom severity, reduction of target behaviors that impact residents' ability to function, improving ability to relate to others, increasing activities of daily living, and overall quality of life. In order to disseminate this best practice this poster will provide a policy including: development, implementation, inclusion/exclusion criteria, non-pharmacological interventions, and the importance of a n interdisciplinary team.

Implications

The concept of the SFC can easily be implemented into a broader health care sector both nationally and globally. The goal of this presentation is to provide and recommend the SFC policy to other facilities who treat residents with severe mental illness resulting in aggression and violence. Implications include expanding this SFVAMC best practice to the global arena.

Learning objectives

1. To raise awareness of the impact residents who suffer from severe mental illness resulting in aggression and violence have on nursing home settings and providers.
2. To increase knowledge and understanding of a best practice to better treat behaviorally challenging individuals with severe mental illness resulting in aggression and violence in long-term care settings.

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Suicide rate rises in hospitals: people detained in "penal complexes" for nonpayment of bills frequently consume deadly detergents

Workshop

Linda Beri Nfor, Pius Defang, Thadeus Asaah
Cameroon Link, Cameroon

Focus: Policy

Cameroon is located in Central West Africa with an estimated population of 20 million people. Though the country which gained independence from the French in 1960 has enjoyed considerable political peace and stability, one of its major social challenges has been its deteriorating public health condition. Poverty remains a fundamental barrier in both urban and rural settings. Recent World Bank statistics show that over 52% of the people in poor household are women and half of them are less than 15 years old. Declining incomes, high illiteracy rates, lack of job opportunities, access to health care, water and sanitation have been identified as the main causes of poverty. The World Bank which rated Cameroon as one of the Heavily Indebted Poor Countries (HIPC) of the world in 2006 holds that more than 30% of the country's population currently live on less than $1 per day.

Disease Burden

The recent UNAIDS reports classify Cameroon among the HIV worst affected countries in Sub Saharan Africa, with a prevalence rate of 5.3 per cent. It is estimated that more than 600,000 people live with AIDS. Malaria is endemic. It constitutes the leading cause of sickness and mortality, accounting for as much as half of all medical consultations and 30% of hospitalization (Global Health Report, 2007). Sleeping sickness, cancer, meningitis, tuberculosis and other cardiovascular diseases are a permanent threat to social peace.

The poor health conditions have been aggravated by porous health policies, the absence of health insurance and lack of basic medical facilities, especially in rural settings. In urban centers, emergency care and hospitalization for major illnesses and surgery are grossly hampered by the lack of trained specialists, outdated diagnostic equipment, crumbling infrastructure, poor sanitation and corrupt health officials who siphon equipment and material from public hospitals to private clinics. Physicians and nurses require bribes, incentives or immediate cash payment for health services, even in emergency units.

Hospital Prisoners

The erection of electrified barriers in both public and private health facilities in Cameroon is not designed for patient care. Rather, it is intended to prevent patients who cannot settle hospital bills from escaping. The prerequisite for hospitalization is admission fee. Once paid, first-aid treatment can be administered, especially in emergency units, once the patient presents a surety who undertakes to pay the bills. But most of the sureties hardly honor their engagements. They flee after appending their signatures primarily to secure the life of a loved one. In such cases, the patient faces indefinite detention in the *"penal complex"* of the hospital while the surety is hunted. Otherwise, the patient is reprimanded to the law court where he or she is judged for *"abuse of confidence"*. In some cases, the hospital authority has required the patient to pay the bills with hard labor. Many of such patients spend years clearing the yard and cleaning corpses under subhuman conditions.

Consequences

Hospital imprisonment is considered a naughty form of humiliation to individuals and the family. Many victims, both in private and public hospitals, either die of hunger, hospital acquired infections or commit suicide. The choice of suicide has recently become rampant. Detainees either consume detergents in the mortuary and laundry rooms or simply hang themselves. In 2011, 13 cases of suicide were recorded in public hospitals while four cases occurred in private health facilities. We must admit that most of the cases go unnoticed since family members who fear to show up cannot alarm. The corpses of undocumented victims are handed to the local councils, sometimes with faked death certificates.

Methods/Acknowledgment

We highly acknowledge the contributions of our staffs who pay regular visits to *"penal complexes"* of both public and private hospitals; our paid agents who monitor the hospital systems, especially mother and child care; the National Commission for Human Rights and Freedoms which regularly probe public hospitals to ascertain the rights of patients; the Association of Cameroon Philanthropic Lawyers (ACPL) whose members sometimes volunteer to defend the detainees; Divisional State Counsels, the police and gendarmerie officers who statutorily authorize the burial of people who commit suicide, as well as the news media which frequently report the gruesome cases.

Learning objectives

1. Policymakers ought to redefine strategies of extending healthcare services to the poorer sector of the community;
2. make the hospitals a home of hope, not golgotha and uphold the dignity of every patient, no matter how poor he or she may be.

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Announcement

The Fourth International Conference on Workplace Violence in the Health Sector will be held on the 22nd till the 24th of October 2014 in Miami, Florida, USA.

The call for abstracts will be issued in October 2013
on the conference website www.oudconsultancy.nl
Please reserve these important dates in your agenda.
Looking forward to seeing you in Miami, Florida, USA in 2014.

Linking local initiatives with global learning

Work-related aggression and violence within the health and social services sector are major problems which diminish the quality of working life for staff, compromise organizational effectiveness, threaten workers' health and ultimately impact negatively on the provision and quality of care. These problems pervade both service settings and occupational groups.

The specific aims of the conference are to:

- Sensitize stakeholders to the issue of violence in the health care sector,
- Understand the manifestations and the human, professional and economic implications of violence in the health care sector,
- Promote effective sustainable initiatives and strategies to create safe environments for workers and clients in the health care sector, and
- Present initiatives which respond to the problem, and have transferable learning for efforts in broader service and geographical contexts.

The key theme of the Conference on this occasion is focused on initiatives which inform responses to the complex problems of aggression and violence within the health sector.

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