

Fifth International Conference on
**Violence in the
Health Sector**
Broadening our view - responding together



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KAVANAH

Violence in the Health Sector



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Editors

Violence in the Health Sector

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Broadening our view – responding together

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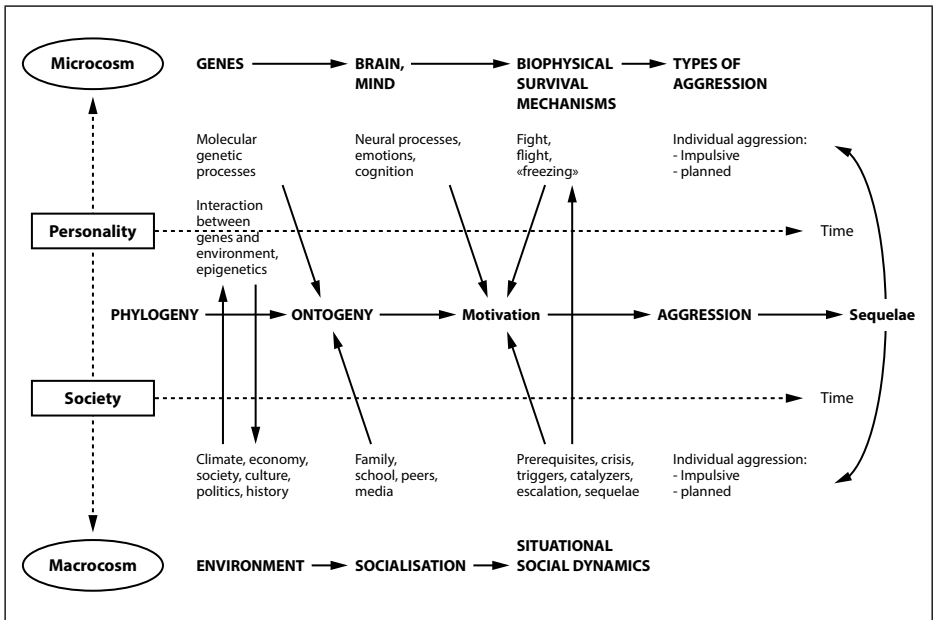
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Preface

In 2009, Professor Klaus Wahl of Germany published an interesting, comprehensive analytical model of aggression and violence that links microcosmic and macrocosmic levels (Figure 1). The level of the microcosm encompasses genes, the brain and psychic processes, bio-physiological survival mechanisms and various types of aggression. The level of the macrocosm encompasses the environment, socialization and situation-induced social dynamics. Between these two poles lies the interplay of an individual's personality and society determines the phylogeny (development or evolution of a particular group of individuals) and the ontogeny (origination and development of an individual) of violent behavior.

Figure 1: Wahl's (2009) Model of analytical levels of aggression and violence, reproduced with kind permission of Professor Klaus Wahl, Munich, Germany.



This model – although probably not yet well known beyond the boundaries of German-speaking countries – allows for a comprehensive understanding of the “big picture” of aggression and violence at the societal and the personal level and may thus be appealing to persons working within the health sector. Dr. Kevin McKenna once remarked that whilst societies certainly show much variation in their levels of violence, health care systems around the world seem to be confronted with rather similar challenges regarding aggression, violence and hostile behavior. This “common denominator” has attracted many conference participants from around the world to the past four conferences and attracts you now to this year’s conference in the beautiful City of Dublin.

It is the wish and the endeavor of the conference organization to offer a platform of exchange and learning to presenters and participants alike. By setting specific missions for the conferences

– “Together , creating a safe work environment”, “From awareness to sustainable action”, “Linking local initiatives with global learning” and “Towards safety, security and wellbeing for all” – the organizers have tried to influence and facilitate the exchange and learning processes. The model of Professor Wahl seems to support the choice of the mission for the present Dublin conference – “Broadening our view – responding together”. The keynote addresses and the special workshops thus contain many of the themes in the comprehensive model: “A Metastructure of Violence: Roles of the Health Sector” (Odile Frank, USA), “A rights-based perspective on violence” (Patricia Rickard-Clarke, Ireland), “A multi-stakeholder approach to violence” (Peter Peerdeman & Bernadette Schomaker, The Netherlands), “Towards a Charter for collaboration between users and professionals” (Wilma Boevink, The Netherlands), “The challenges of challenging behavior” (Jiska Cohen Mansfield, Israel), “Forms of neuro-cognitive dysfunction that increase the risk for violence” (James Blair, USA), “ICN Position statement on violence” (Frances Hughes, Switzerland), “From conflict, through peace process to reconciliation” (Geoffrey Corry, Ireland) and “The choreography of catharsis: Recognizing, responding, and recovering from violence in the health sector” (Patricia P. Capello, USA).

In this vein the conference organization extends a warm welcome to all presenters and participants and is confident that Dublin will be the place to broaden your view and help us all respond together.

Literature

Wahl K (2009) Aggression und Gewalt: Ein biologischer, psychologischer und sozialwissenschaftlicher Überblick. Heidelberg, Spektrum Akademischer Verlag.

The organization committee

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Howard Catton

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Franklin Shaffer

Note on the peer review process of the conference

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 –provisional acceptance pending amelioration of the abstract. On applying this procedure, the Organization Committee endeavors to do justice to all submitters and to the Conference participants, who are entitled to receive state of the art knowledge at the Conference.

For the present conference 232 abstracts from 44 different countries worldwide were submitted, however 2% was rejected by the scientific committee, and 23% were unable to attend. So in the end the conference program included 187 presentations (keynotes, workshops, papers and posters) from 37 countries worldwide.

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.

Please note, however, that the conference organization will not accept liability for presenters' content. Conference presenters are personally responsible that they have adequate authorization regarding all aspects of their presentations, should such authorization be required, for example from co-authors or financial sponsors.

The conference organization is in no position to negotiate and/or arbitrate any issues of conflict arising from the lack of authorization, copyright disagreements or other such and similar issues of authorship or content.

In Memoriam

It was with great sadness that we learned that our scholarly colleague and good friend **Vaughan Bowie** [RIP] died earlier this year.

Vaughan was a stalwart member of the scientific affairs committee of this conference, a position which reflected not only his commitment to best practice, but also his status as a widely published academic who made significant contributions to the literature on workplace violence prevention.

Vaughan was interested not only in theory, but also in practice and teaching, and his wide travels served to bring many in the emerging violence prevention community together fostering collaboration and positive change.

It is fitting that in our work this week, we remember Vaughan's many insights and celebrate his many valued contributions.

Ar dheis Dé go raibh a anam

Suaimhneas síorai da anam

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- American Nurses Association (ANA)
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- British Columbia Nurses' Union (BCNU)
- British Institute of Learning Disabilities (BILD)
- Canadian Federation of Nurses Unions (CFNU)
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- Friends Hospital
- Health and Safety Authority
- Health Sciences Association of BC (HSABC)
- Hospital Employees' Union (HEU)

-
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 - International Confederation of Dietetic Associations (ICDA)
 - International Confederation of Midwives (ICM)
 - International Council of Nurses (ICN)
 - International Hospital Federation (IHF-FIH)
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 - IntraHealth International
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 - Irish Nurses & Midwives Organisation (INMO)
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Chapter 1 – Keynote speeches

A Metastructure of Violence: Roles of the Health Sector

Keynote speech

Odile Frank

President, NGO Forum for Health, Geneva, Switzerland

Violence in the health sector has always occurred and continues to occur in the context of violence that is global, regional and local. The evidence of violence in the broadest context, its particular manifestations and trends in forms of violence have implications for the health sector in three major ways: the health sector is implicated in providing services to victims of violence; the health sector is affected by violence in society at large with resulting levels of violence in the health sector itself; and the health sector has a duty to care which obliges it to take a stand on violence both inside the health sector and in society at large.

The health sector provides services to victims of violence

The first of these major issues – the role of the health sector in health service delivery to victims of violence – will not be treated further here. It is a vast subject in itself which engages the commitment of health workers everywhere. It is important to note, however, before leaving this topic, that in helping others in situations of violence, health workers expose themselves to enormous risk. A good study by the International Committee of the Red Cross (ICRC) has taken the measure of the violence they experience (ICRC, 2011). Most recently, the violence experienced by health workers delivering services in areas of conflict, notably in Western Asia and the Middle East, has reached extraordinary proportions. It is a topic that we cannot ignore, but must set aside for the moment.

Today we will focus on the impact of the level of violence in society at large on the level of violence in the health sector and the need for the health sector to take a stand on violence in society at large as well as in the health sector.

The health sector is affected by violence in society at large

It is well to start by reminding ourselves where we are historically with respect to the occurrence of violence, and also to map violence as well as the evidence permits. At this time, in 2016, the world is 70 years after the Second World War and many events have occurred that are associated with violence.

On the positive side, decolonization and the new focus on social and economic development were beneficial for developing country societies, where a decline in absolute levels of poverty has marked the period since 2000, especially in China and in Brazil. In developed countries, a three-decade era of prosperity in the after-war period led to a long and beneficial era in social welfare. In the so-called Second World, the cold war was replaced by the disappearance of communist regimes. Over the entire period, multilateralism grew, with some ups and downs, and principles of human rights saw their ascendancy. The transformations due to digital technology and the creation and expansion of the internet assisted all these changes in many and varied ways.

Nevertheless, the period also saw persistent conflicts, both internal and inter-country, in several regions of the world, for example in East Asia (notably the Korean and Vietnam wars); in Africa (multiple conflicts, see Marshall, 2006); in Europe (the deconstruction of the former Yugoslavia) and in Latin America (for example, the Falkland-Malvinas conflict). In the latter part of this period, major inter-country conflict occurred in Afghanistan, Iraq and Syria, with repercussions for several other countries of the region.

Importantly, the period also witnessed the rising dominance of neo-liberal economic policy in market liberalization, financial deregulation and economic globalization, which, we will argue, are perceived as new and potent sources of violence (see, for example, Springer, 2016).

Coming back to 2016, then, we can identify several epicentres of violence. The first is still wars and conflicts.

Epicentre of violence: War and Conflict

There is good evidence and improved scientific methodology to measure the recent increase in violence from civil wars and the very long-term persistence of general levels of conflict (Einsiedel, 2014; Cirillo and Taleb, 2015). Einsiedel points to the tripling in recent years (since the 1990s) of major civil wars, along with tripling of battle deaths. Between 2007 and 2014, civil wars tripled to 11 that include Iraq, Afghanistan, the Democratic Republic of Congo, Somalia, South Sudan, Syria, the Central African Republic, Libya, Ukraine, Pakistan and Nigeria. He adds that conflicts are becoming more intractable due to factors such as organized crime, internationalization of civil war and the growing presence of extremist groups who intimidate even assigned peace-keeping operations. Cirillo and Taleb apply new statistical methodology to 2000 years of historical data on conflict and conclude that their results contradict the notion that violence has been declining with time. They point to several ways in which war dead have been underestimated. Although they cannot assert that violence is increasing in time, they can demonstrate quite well that there is no evidence for a decline in violence: “at least in the last 500 years humanity has shown to be as violent as usual” (Cirillo and Taleb, 2015: 12).

War and conflict are insidious in their design as well as in their consequences for societies, in many ways. Engaging in conflict exploits youth and disrupts civilian populations. Both lead to the persistence and perpetuation of violence.

The exploitation of immature youth

Military conscription is most often legally at the age of 18 years. Aside from the fact that underage conscription and child soldiers are a major scourge of our age as well as of history (currently an estimated 250,000-300,000 boys and girls are fighting and servicing troops in an estimated 10-14 countries, many of which receive US military aid, according to organizations such as Human Rights Watch and World Vision), even the age of 18 presents a range of issues that point to the fact that war and conflict rely on immaturity, especially of men.

Current research on brain development and on human behaviour underscores the finding that structural changes are still occurring in teenagers’ brains and the period of brain growth and change continues until the mid-20s (Johnson *et al.*, 2009). Domains of development vary in their speed over these years. Cognitive skills of planning and impulse control develop later, behind the capacity for emotional response. According to the National Institute of Mental Health of the US, “one interpretation of [...] these findings is that in teens, the parts of the brain involved in emotional responses are fully online, or even more active than in adults, while the parts of the brain involved in keeping emotional, impulsive responses in check are still reaching maturity. Such a changing balance might provide clues to a youthful appetite for novelty, and a tendency to act on impulse—without regard for risk. [As a result], mortality rates jump between early and late adolescence. Rates of death by injury between ages 15 to 19 are about six times that of the rate between ages 10 and 14. Crime rates are highest among young males and rates of alcohol abuse are high relative to other ages...” (NIMH, 2016).

War and conflict exploit the rapid emotional trigger of adolescence and rely on the capacity of young soldiers to engage in risk-taking behaviour that is not countered by a maturity of judgement until the mid-20s. Clearly this is itself a form of violence against the young, especially males.

War, conflict and the disruption of the civilian population

In the presence of war and conflict, civilian populations seek refuge. Whatever the response, it is in essence a transformation into refugee status. Populations move away from fighting and the risks of injury and death from armed conflict through relocation and displacement within countries, and outright migration when they need to move away from their country into another country for safety. Relocation, displacement, outmigration or emigration and immigration are all violent events in the lives of people.

In these ways, war and conflict are not only violent undertakings themselves, but they serve to make war and conflict epicentres of violence, of which the most notable consequences are, over and above death and

injury of the military and civilian populations, the cynical exploitation of the young and the life-altering experience of the entire population in its exposure to massive levels of insecurity that lead to displacement and emigration in search of safety.

Epicentre of violence: Discrimination and Racism

Although cohabitation of different cultures, civilizations, races and religious beliefs is a reality of our world, successful cohabitation is less noted, taken for granted and probably less studied than are discrimination and racism based on human differences. These differences do not need to lead to inter-group violence, therefore, but they do lead to extraordinary levels of violence given a number of conditions, which may or may not lead to the levels of violence in conflict and war, or be bound up with other factors that lead to war and conflict.

Violence associated with discrimination and racism is founded on identifying and stereotyping the targeted group. Any attribute of the other group is grounds for discrimination and racism, and they have been levelled at one time or another and in one setting or another on the basis of age, sex, race, ethnic origin, religious belief, sexual identity, sexual preference and so on. Some forms of discrimination are institutionalized and such institutionalization is still widespread. Any numbers of examples come to mind. All forms of discrimination can lead eventually to violence, especially if the stereotyping is associated with a dogmatic intolerance of the difference.

Epicentre of violence: Rape, Gynocide and Domestic Violence

Although discrimination and racism (sexism) against women and girls can be interpreted as just another form of discrimination and racism, it needs to be singled out for several reasons. The first is that women and girls are not a minority in any sense of the word, whereas discrimination and racism often target minorities. Second, the most fundamental violence – sexual violence - is perpetrated against women and girls, which is not necessarily present in the violence acted out against other targeted groups.

Rape is injurious physically and psychologically. It relies on dominance of the female body and can lead to long term injury, whether in the form of damage to the body, persistent psychological trauma, or pregnancy that binds the victim to the aggressor and creates new and damaging consequences for the children of rape. Rape on the scale of war is gynocidal, as data show that a significant proportion of victims simply do not survive, especially from gang rape, and the intent of the perpetrators is as much to destroy the resolve of the entire population as to destroy female bodies attacked by this means. According to the United Nations, this ““conflict-related sexual violence” refers to rape, sexual slavery, forced prostitution, forced pregnancy, forced abortion, enforced sterilization, forced marriage and any other form of sexual violence of comparable gravity perpetrated against women, men, girls or boys that is directly or indirectly linked (temporally, geographically or causally) to a conflict” (United Nations, 2016).

Notwithstanding the viciousness of conflict-related sexual violence, domestic sexual violence is more widespread. Most domestic violence is perpetrated by intimate partners. Recent data from the World Health Organization reveal that “about 1 in 3 (35%) of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime...Most of this violence is intimate partner violence. Worldwide, almost one third (30%) of women who have been in a relationship report that they have experienced some form of physical and/or sexual violence by their intimate partner” (WHO, 2016). Furthermore, the United Nations reports unconscionable levels of sexual violence against girls: “Around 120 million girls worldwide (slightly more than 1 in 10) have experienced forced intercourse or other forced sexual acts at some point in their lives. By far the most common perpetrators of sexual violence against girls are current or former husbands, partners or boyfriends” (United Nations, 2016).

Epicentre of violence: Education and Communication

It may be surprising to see education and communication associated with sources of violence. But education, both in its form and content can engender violence. When education is dogmatic, brooks no discussion and leaves no room for questioning, interacting or contesting, students of the education are victims of intellectual violence, and can act violently themselves as a result. Content of educational messages and the specific information conveyed by education can be even more so conducive to violence, as the content can argue for practising discrimination and racism and identifying groups of persons as targets.

Transmitting information in educational and communication settings can be purposefully confounded with proselytization of beliefs and indoctrination, especially when both the form of education is unquestionably didactic and its content strictly dogmatic.

Furthermore, education and communication that are based on information that is not scientifically grounded, but more so based on ideology, are forms of intellectual violence, which can engender violence both through making it impossible to contest the information, as the victims are unable to express any form of opposition, and by fostering intolerance expressed towards others that may be acted out in violence.

Epicentre of violence: Poverty and Economic Transformations

It is a commonplace to point out that poverty can be soul-destroying. In this way, it is a form of psychological abuse and squarely an epicentre of violence. Hobbes, a philosopher, characterized a life deprived of integration into an economy or society as a life that is “solitary, poor, nasty, brutish, and short” (Hobbes, 1651). This is often the case for persons living in developing countries and surviving outside the formal economy.

Notwithstanding the advances made in economic and social development since the mid-1940s, and actions taken to address the specific goal of poverty eradication of the Millennium Development Goals that have guided multilateral policies and assistance since 2000 – and that resulted in remarkable reductions in absolute poverty in China and Brazil in particular - grinding poverty still plagues billions of persons on earth.

A new factor in poverty, furthermore, is that the differences between the poor and the not-so-poor, and the rich are now quite transparently communicated on the internet and by the media. As connection to the internet has globalized, and the mobile telephone has seen an extraordinary expansion, poor persons have an open window on how others live, both inside and outside their countries. Differences that can be seen and assessed and that lead to very unfavourable comparisons are experienced as a form of violence; the violence of deprivation in the midst of plenty. At the same time, economic conditions in developed countries have led to persistent pockets of poverty, following on the financial and economic crises of 2007-2008.

The economic transformations that were already ongoing and that were the backdrop for the crises - economic liberalization, financial deregulation and globalization – had already showed up some consequences that were experienced as violent changes, among them the sharp decline in industrial jobs in the former industrial belts, persistent unemployment, ageism in the labour market, the rarefication of job security, and wage stagnation. At the same time, the delocalization of hundreds of millions of jobs to developing countries such as China led to declining prices for goods that trapped developed country consumers in contributing themselves to the economic transformations that were taking place.

Associated with the crises, the bank bailouts were perceived as favouring the rich whereas the home foreclosures jeopardized the assets of the lower and middle working classes. The crises themselves and the bank bailouts threatened the creditworthiness of governments, and the response in austerity budgets reduced public employment and led to cutbacks in public services, as well as diminishing the capacity of the state to regulate. As public health and educational services were shoe-stringed, there was increased privatization of health care and health care has become notably more expensive, as has education. In respect of housing, the market renewed an upward trend in prices, whereas home ownership was hamstrung by a post-crisis retraction in the availability of credit for mortgages.

It may be even more surprising to think about economic competitiveness in the context of violence. Yet at the very base, competitiveness requires besting someone else in order to rank better. As with other epicentres of violence, there is no obligatory pathway from economic competitiveness, but the drive for productivity and the occurrence of abuse that are violent in their nature are present in every component of economic achievement. The profit motive is stimulated by a need to obtain material benefits from others. While competition is regulated, there are major checks on abuse that can occur designed to protect those who are materially the consumers or debtors in an economic relationship. But deregulation leaves consumers and debtors more exposed and the door open for cupidity and greed. Most egregious is the pursuit of profit and wealth that far exceeds need. In recent years in the major western economies, a small number of persons have acquired extraordinary assets and wealth under growing deregulation, which of itself is perceived by populations as a form of violence. This is even more so as the earning capacity of work has stagnated for several decades in parallel with increasing globalization. The middle-classes of workers have advanced little if at all, but observe that some have become exceedingly wealthy, and this great divide is a major source of dissatisfaction and growing intolerance. The perception from the bottom is that money flows to the top in a form of Pyramid Scheme, whether the working middle classes buy into it or not, and that the gains at the top are entirely their loss in an overall zero-sum economy.

Whatever basis these perceptions have in reality, research shows that the most recent decades have led to growing inequality at several levels. The last decades have seen a rise in the power of multinational

corporations, and a disproportionate increase in the numbers of millionaires and billionaires. This rise in wealth could still benefit countries through taxation, but multinational corporations in particular have been able to avoid taxes that could have benefited the public revenue of numerous countries by a mechanism of base erosion and profit shifting, which consists of using legal loopholes to move profits to locations where taxes are lowest or non-existent (OECD, 2016; ICRICT, 2016).

Finally, it is worth noting that both poverty and economic transformations set off refuge-seeking and migratory flows. In our current world, however, whereas financial deregulation, multinational actions and the diminishing capacity of the state to regulate have led to increased mobility of capital, the mobility of persons is a focus of increasing control at the demand of populist and nationalistic politics and there is a strong motivation to check the difference between political and economic refugees and migrants. This state of affairs not only challenges any interpretation of the Universal Declaration of Human Rights and the right to movement, but is inconsistent with the pressures to release remaining controls on the flows of capital. Money can move, but human beings may not.

A footnote on Terrorism, Mass Killings, Dystopias and Video Games

Thinking about violence in the world of 2016 evokes a range of responses and observers remark on a series of epiphenomena, notably terrorism, mass killings, youth dystopias in literature, and the role of violent video games. These issues deserve more than a footnote, but they are discussed briefly here as parallel to our choice of major epicentres of violence.

Terrorism

Terrorist acts occur virtually daily and are the subject of substantial media coverage currently. The acts are uniformly horrendous, and the occurrence of these acts influences profoundly the sense of insecurity across the globe. The most recent Global Terrorism Index, based on the Global Terrorism Database (GTD) datasets of the National Consortium for the Study of Terrorism and Responses to Terrorism (START) headquartered at the University of Maryland in the USA, was produced by the Institute for Economics and Peace to document the reach of terrorist acts (IEP, 2015).

The report confirms that acts of terrorism are increasing in frequency and the number of deaths is also increasing, based on the most recent data. Between 2014 and 2015, terrorist acts increased by 80 per cent, and the number of deaths rose from 18,111 in 2013 to 32,685 in 2014. In effect, the number of persons who have lost their lives due to acts of terrorism rose 9 times between 2000 and 2014. According to the report, Boko Haram and the Islamic State of Iraq and the Levant (ISIL) were equally the worst and the most deadly in 2014, when Boko Haram claimed the lives of 6,644 persons and ISIL 6,073.

Fear of terrorism, fear of insecurity and actions to prevent and defend against terrorist acts have become virtually global. Terrorist activity is occurring in a number of countries, but the burden of terrorist deaths and the most frequent acts of terrorism are more concentrated than appears in the public view. The majority of terrorist attacks (nearly 3/5 attacks or 57 per cent) occurred in only 5 countries in 2014 – Afghanistan, Iraq, Nigeria [1], Pakistan and Syria – and the vast majority of deaths (nearly 4/5 deaths or 78 per cent) occurred in those same 5 countries. Although a majority of countries experienced a terrorist incident of one type or another in 2014 (93 countries, which is 3/5 or 57 per cent), of the 162 countries covered by the data base, 95 or 3/5 experienced no terrorist deaths that year, and the remaining 67 countries experienced 1 or more deaths.

It is true nevertheless that terrorism is increasing and expanding geographically. The countries that experienced over 500 deaths increased by 120 per cent in 2014: whereas only 5 countries experienced over 500 deaths in 2014, 11 countries experienced over 500 deaths in 2013. Furthermore, the civilian population is increasingly targeted by terrorist attacks. Deaths of non-combatant persons increased by 172 per cent from 2013-2014, as compared with the total number of deaths which increased 80 per cent.

Aside from the geographical concentration of terrorist attacks and deaths, three further aspects of terrorism should be considered in assessing the potential contribution of terrorism to global levels of violence.

- First, homicides are responsible for the deaths of 13 times as many persons as deaths due to terrorist attacks (nearly half a million or 437,000 deaths in 2014). Homicides contribute far more to the actual level of violence globally, whereas terrorist attacks likely contribute disproportionately to the levels of fear and protection from violence. In this sense, terrorism succeeds in terrorizing the global population.
- Second, ISIL, which is one of the two deadliest terrorist entities, actually inflicts a far greater number of deaths in the battlefield. As compared with the 6,073 deaths attributed to terrorist attacks by ISIL in 2014,

ISIL inflicted more than 3 times that number of deaths in the battlefield (an estimated 20,000 deaths of combatants of different types).

- Third, root causes of terrorism must be examined. As has been evident for some years, and is increasingly covered by the press, a large proportion of combatants in Iraq and Syria actually come from outside the region. According to IEP, 25,000-30,000 foreign combatants entered the two countries between 2011 and 2015, 7,000 in the first 6 months of 2015 alone. If one excludes Turkey, which contributes about 4 per cent, 21 per cent of foreign combatants were from Europe in 2014. More than 50 per cent were from countries neighbouring Iraq and Syria, and from North Africa.
- Clearly, it is incumbent on us to reflect on the root causes of this movement of mostly young men not only from areas that are geographically close to the ongoing conflicts, but from areas such as Europe, where insufficiently integrated young generations are experiencing a degree of economic and social violence due to their alienation from educational and labour market institutions.

Mass killings

Non-terrorist mass killings similarly raise fear to alarming levels in many settings. There are not many sources of detailed data on mass killings globally, but Mother Jones, a non-profit investigative news outlet in the USA recently updated their 2012 database and report on mass killings by shooting in the USA that had also been reported by the Boston Globe newspaper (Mother Jones, 2016; Boston Globe, 2015).

According to Mother Jones, there were at least 83 incidents that fit the criteria of mass shootings between 1982 and 12 June 2016, and more than half of them – 47 killings – occurred since 2006, and 7 in 2015 alone. A research study on the database in 2014 confirmed that the rate of mass shootings had tripled between 2011 and 2014 (Cohen *et al.*, 2014). Criteria for a mass shooting include that the perpetrator killed at least four people, excluding him or herself; the killer was a lone shooter; that the shootings occurred in a public place (including sprees that led to shootings in several locations); and that shootings that are primarily gang-related, associated with armed robbery or due to domestic violence in homes are not included. According to the mass shooting tracker project, however, if one considers shooting injuries as well as deaths, there were 371 incidents involving 4 or more persons in 2015 alone which led to the deaths of 469 persons and to 1,387 injuries (Gun Violence Archive, 2016).

These mass shootings are grievous in that the majority are associated with legally obtained weapons (more than ¾ of the 143 guns used in the shootings covered in the Mother Jones' data base), and they are increasing despite the decline in home ownership of guns in the USA (ownership declined from about 45 per cent of households to about 30 per cent between 1973 and 2010) and the overall decline in firearm homicide deaths in the USA from about 7 per 100,000 population in the late 1980s and early 1990s to under 4 per 100,000 population in 2000-2010. The killings frequently used assault weapons.

It is tragic also that more than half the shootings covered in the Mother Jones' files took place in school or workplace settings, with other public settings involving shopping malls, restaurants and religious and government buildings. Much research has been devoted to profiling these killers, who are for the most part white, rarely female (a single perpetrator according to Mother Jones), on average 35 years, and frequently with pre-existing mental health problems.

Although such detailed data are available for the USA alone, there have been similar mass shootings in recent years in other countries, such as in Europe, notably two major massacres in Scotland and in Norway. Researchers point out, however, that overall assault deaths per 100,000 population are substantially fewer in other countries (Healy, 2015).

Mass shootings contribute without a doubt to an overall feeling of insecurity, notably in the USA, and to responses that may be contradictory, such as surges in legal gun ownership for defensive purposes. That these mass shootings are an epiphenomenon that is highly related to the culture and history of the USA appears evident, and increases in mass shootings in the USA should not be held up as definitive examples of the increased level of violence globally.

Dystopias and Video Games

Recent youth literature that is noticeably dystopic, such as “Hunger Games” and “Divergent” led to discussions regarding whether youth are becoming more violent in their tastes. Yet earlier generations have had remarked contributions from dystopic authors, in particular in the field of science fiction, and in fact examples abound.

Similarly, there has been substantial concern over violent video games. But here, there has been more research, and there seems to be evidence that playing violent video games may increase aggressive outcomes (Bonus *et al.*, 2015), lead to desensitization of certain brain regions (Indiana University School of Medicine, 2011) and with repetitive playing have decreasing capacity to elicit guilt (Grizzard *et al.*, 2016).

The degree to which violence in youth is affected by influences such as dystopic literature and cinema, and violent video games, and the degree to which youth both choose these sources of influences and/or act out on the basis of these influences are topics of continuing research.

Responses to violence

We have seen in the foregoing that there is a range of responses to violence that may be direct or indirect, and all engage the health sector in one way or the other. Among direct responses, the most evident is violence itself. Violence begets violence, and it is enough for us to point out here that there is a long history of concern, in particular in philosophy and in the study of politics, regarding the appropriateness of violent responses to violence, on the justification and moral basis of war. We will not address these issues but point out that our concern is with violence as a context for other human activities, notably delivering health services.

We have also see that an important response to violence is flight, and the fact that large numbers of human beings have sought refuge from violence throughout history and at exceptionally high levels in recent times is a further factor to consider as a context for delivery of health services.

We have also see that there are indirect responses to violence; one could possibly classify the influence of violent video games here, because of the simulated nature of the violence in this case. But indirect responses can also refer to what is known as “compassion fatigue” that has been observed in populations that are not directly affected but who have been solicited repeatedly to come in aid to the victims of violence. Closely associated with this, “burnout” is a syndrome that has a high occurrence across all the helping professions, notably in the health services.

Finally, there is the important consequence of post-traumatic stress disorder (PTSD) that occurs first and foremost in victims of violence, but also occurs after witnessing a violent event. There are few global data for PTSD, but it is clear that it occurs everywhere, and that women may be more likely to develop PTSD than men. PTSD is of primary concern to the health services community.

An Agenda for the Health Sector

We argue here that the health sector cannot adequately address violence in the health sector without taking a stand on violence in society at large, and, with our broadening global view, on violence as a global phenomenon.

Moreover, the nature of health and social care services means that professionals across the spectrum of services have a “duty of care” and are particularly sensitized to the impact of violence on societies in their daily work and in their engagement or commitment to the health and welfare of human beings.

Accordingly, I propose 4 actions that could comprise an agenda for the health sector in taking a stand on the level of violence in society at large and globally. They appear to me to be essential in order to make sense of and increase the feasibility of effectively preventing and managing violence in the health sector itself. They are critical for the success of policies, programmes and actions to limit violence in health care settings themselves.

1. Serving to block the penetration of violence in health settings

Health settings and health professionals may not only help to reduce the level of violence in health settings, but proactively limit the penetration of violence into health settings, by creating firewalls, both physical and virtual. This could be underscored in conjunction with the second action, of proactively promoting health care settings as violence-free zones.

2. Creating health sector safe zones, safe places and safe harbours

Making health sector settings safe zones would mean both identifying what is kept outside and what is promoted inside. It means:

- a. Informing the staff and the public about the violence in society and globally that the health care setting has decided to take a stand on

- b. Messaging safety at all contact points with the outside world
- c. Developing an ethos and culture of safety that is particular to the health care setting. It should be owned by the staff of the setting and appropriated by the public who use the services

3. Modelling the stand against violence in society and globally

Health care settings that successfully adopt a stand against violence and engage in awareness-raising can also engage in advocacy to keep violence out of health care settings generally. They can build alliances with other health care settings, and establish networks to promote health care settings as Safe Zones

4. Communicating to society to extend the promotion of safe health care settings

The health care sector is an important institution of all societies. Establishing a culture of safety and refusal of violence within a setting and finding like-minded health care institutions with which to develop sharing networks can be followed by strong messaging to society at large about limiting violence. Taking a stand on violence in society at large and globally can ultimately help shore up policies, programmes and actions for the prevention and management of violence in the health care setting.

Footnote

1. According to the IEP, Nigeria experienced the largest increase in deaths from terrorism in 2014, due to the presence of two of the most deadly terrorist groups (Boko Haram and Fulani militants). Nigeria suffered 7,512 fatalities from terrorist attacks that year, an increase of over 300 per cent.

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A Rights based perspective on violence

Keynote speech

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Abstract

Respecting individual rights of persons whose behaviour may be challenging to include international human rights obligations and compliance with procedures prescribed by law. Examining compliance with the European Convention on Human Rights and the UN Convention on the Rights of People with Disabilities in the context of the Mental Health Act 2001 and the Assisted-Decision (Making) Capacity Act 2015 to include both physical and chemical restraint. The regulatory environment with regard to 'control and restraint' in the healthcare sector and the monitoring of services against national standards.

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Where care and safety meet

Keynote speech

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Keywords: persons with psychiatric problems, care, safety, co-operation

In this paper, it is explained how care and safety are related to each other in the Netherlands. Especially, with regard to persons with psychotic disorders public safety and psychiatric treatment are not always well balanced. In this paper it is explained how care and safety meet each other in the Netherlands.

Safety incidents

On the 9th of April 2011, a young man entered a shopping mall in a small Dutch city. He shot 5 visitors of the shopping mall, wounded another 17 persons and, finally, committed suicide. The young guy had a permission to possess three guns, as a member of a shooting club. After analysis, it was found that the young guy was also suffering from psychotic disorders.

On Monday the 10th of February 2014, the former minister of Welfare and Care of the Netherlands was found dead in her garage. Almost one year later, the police announced that an arrest has been made. It appears that the offender suffered from psychotic disorders. He also murdered his sister and due to this event, a DNA match was found. A large research took place why the psychotic patient was not treated well and why the prosecutor did not react properly on all kind of signals. It was found that psychiatric care and the criminal justice system did not work well together.

The two incidents represent only a small part of all safety incidents with offenders with a psychiatric background. Recently, they got a lot of political and societal attention in the Netherlands.

In the Netherlands these offenders with psychotic disorders are called ‘confused persons’. These confused persons have their ‘good periods’ and their ‘bad periods’. As other countries, we have the possibility of civil law of enforced mental health care for people who are a risk to themselves or to society. There are also a lot of possibilities for forensic care when psychiatric patients commit a crime. However, there are still a lot of confused people avoiding care, due to their mental health illness.

The number of incidents with so called confused persons has augmented enormously: from 40.000 in 2011 to 52.000 in 2013. E.g. between 2013 and 2014 the number of incidents in the region of Rotterdam augmented with 28%.

Let us start with defining the concept of ‘confused persons’: it concerns persons who have lost or might lose the control of their lives, which might cause damage to themselves or to others.

It is about people who have different psychiatric diseases or restrictions (psychiatric, addictions, slightly mentally disabled or dementia), often in combination with social and financial problems (like huge debts, loss of beloved ones, homelessness, lack of participation, uninsured, illegal and so on). Through all kind of circumstances, they may not recover and it can occur that their problems become chronic. Consequently, they avoid care and lose the control of their lives. They can become victims of criminal activities or commit criminal activities themselves.

The general idea is that incidents can be prevented if signaled earlier, and therefore around every patient a closed network of “care and love” has to be arranged. However, through rules and regulations and through high “fences” within and between organizations these networks do not function properly. Nevertheless, due to the above mentioned and to other incidents the need to change this became more and more urgent.

In September 2015 the ministries of Welfare and Care, Safety and Justice and the Association of Dutch Municipalities (VNG) formed a task force. The aim of this task force is to develop tools and guidelines for local governments to signal psychiatric problems earlier and prevent incidents. It also develops tools for supporting people with psychiatric problems and their families. The recommendations are based on the knowledge and experiences of about 60 organizations involved, like mental health organizations, organizations of psychiatric

patients and their families, knowledge institutes, housing corporations, primary health care and so on. In September 2016 this Taskforce will present its final conclusions. But whatever the recommendations will be, probably the best result of this Taskforce is that it succeeds in gathering all involved parties around one table. The sense of urgency is felt now and all noses are directed towards the same direction.

In the following section, we explain more about the ways in which safety and care are organized in the Netherlands.

The organization of safety

• Local governments

In the Netherlands the final responsibility for safety issues is given to municipalities. Municipalities are managed by a mayor who is also the chairman of the municipal council.

In safety issues, the mayor has a special role, as the head of the police at local level. He bears responsibility for the public order. Every four years a safety plan is made up, in which the local priorities are worked out. At the local level, the mayor is one of the main actors to connect safety and care as he has special legal authority with regard to enforced treatment of confused persons, suffering from psychotic orders and being an acute risk to society or themselves. Although the mayor is responsible for local safety issues, the implementation of safety policy is in the hands of different organizations.

• The police

Since 2014 the National Police Force of the Netherlands is in a reorganization. Nowadays the Dutch national police force consists of ten Regional Units, the Central Unit and the Police Services Centre. Each regional Unit is managed by a Chief Constable. Within one regional unit there are several municipalities, depending on the number of inhabitants. The reorganization has a large effect on the daily work of police officers. Work processes have changed and a lot of functions have been shuffled. Primarily the police is responsible for maintaining laws and regulations. Police officers prevent people from committing offences and crimes by being visible present on the street, on foot, by bike or in a marked car. They perform detective work and investigate mayor crimes, give advice on prevention of crimes, provide assistance, deal with traffic issues and so on. The Dutch government is keen to put more and more police “on the street”.

• Public Prosecution Service

The second major organization involved is the Public Prosecution Service. Its highest authority, the board of Procurators General, lays down policy on investigations and prosecutions. The board and its staff form the service’s national office. The Public Prosecution service has offices – the public prosecutor’s office – in ten districts (in accordance with the ten Regional Police Units). Each of these district courts is under the authority of a chief public prosecutor. Since 2011 the Public Prosecution Service has introduced the so called ZSM-method. The ZSM-method is a co-operation between Public Prosecution Service, the police, Rehabilitation Service, the Child Care and Protection Board and Victim Support. Light cases – like smaller aggression incidents - will be evaluated within six hours. If there are no special circumstances the Public Prosecution Office will offer the delinquent an adequate punishment. If accepted the case will be closed. More severe incidents will be treated through regular legal procedures.

Triangle

In each of the ten Regional Police Units decisions about the principal law enforcement policies are made by a regional board, the so-called Triangle. The chairman usually is the mayor of the largest municipality in the region. The other board members of the Triangle are the chief constable and the (chief) prosecutor.

The organization of mental health care

In the Netherlands the primary care acts as a gatekeeper for all health services, including mental health care. Family doctors, nurses and psychologists identify, treat and offer care for people with mental problems. The specialist mental care services (secondary and tertiary care) is provided by regionally integrated service provider organizations and by a small number of stand-alone community services and mental hospitals. Together these organizations offer about 85% of all mental health services, from ambulatory specialist care, acute inpatient care to community based services.

Since 2015, national government has shifted the responsibility for the provision of care facilities to municipalities, local communities and family. People in need of help are stimulated to stay at home as long as possible, with help from family, friends and care officers. Municipalities are made responsible for decisions

regarding the type and amount of care. The idea behind this is that at local level governments have better insight in the care needs. They are able to provide the right care quicker and more cost efficiently. Moreover it is meant to concentrate help.

Where care and safety meet

As you have noticed, in the Netherlands safety and care come together in municipalities. At local level policies and implementation are arranged. In practice however, this often does not go as smoothly as it is supposed to be. Especially on the field of safety and care much has gone wrong. However, interesting initiatives to overcome this have been taken. Like the following initiatives:

1. Legislation

In the Netherlands the Psychiatric Hospitals Compulsory Admissions Act (Wet Bijzondere Opnemingen in Psychiatrische Ziekenhuizen, BOPZ) regulates the circumstances involved in involuntary hospitalization and treatment in psychiatric institutions. Before involuntary placement can take place a few conditions have to be met:

- There has to be serious harm to oneself, to others or to society as a whole;
- Which is caused by psychiatric disorder;
- As assessed by a psychiatrist;
- That there must be no alternative that detainment to avert the danger;
- And that the patient is refusing voluntary hospitalization.

If all of these conditions are met a judge can decide to detain the patient. It can be enforced through two procedures: an Acute Involuntary Admission (AIA) or a court order (CO). An AIA is used in case of imminent danger. Anyone can request an AIA, but a psychiatrist has to determine if the aforementioned conditions are met. If so, a medical report is submitted to the mayor, who decides whether or not an AIA is issued. If so, the patient is detained within 24 hours. Within one workday of the detainment a public prosecutor decides whether further detainment is necessary. A court order is used to the same conditions, but when there is no emergency.

A court order can be requested by people near to the patient or by the patient himself. An independent psychiatrist assesses the client and presents his medical report to a public prosecutor. If the public prosecutor agrees that detainment is necessary he passes the request to the court, which makes the final decision.

However in the near future the BOPZ will be replaced by the Compulsory Mental Health Care Act (WVGGZ). This new act will only apply for patients with a psychiatric disorder. No longer will admission be central to the law, but the care itself, and it can also be applied outside the walls of the treatment setting. Compulsory care will become obligatory care, and can be given based on care warrants of a care professional. Care warrants will substitute the current law admissions. The risk criterion of the BOPZ law will be replaced by a damage criterion. Also in the WVGGZ the engagement of the family will be enlarged. And there will be some organization changes in the complaints and reporting procedures.

2. Community Teams

In almost all municipalities community teams have been formed. These are teams consisting of different disciplines working in local communities or neighborhoods.

The community teams are formed to:

- Stimulate the participation of citizens, and enhance social bonding and help at community level
- Support citizens to take the responsibility themselves for all kind of life issues;
- Be a contact point for questions and ideas;
- Support the own strength and self-supporting capabilities of citizens;
- Be the portal to more intensive, more specialist care.

The power of these teams lies in stimulating civil participation. Through their close relationships with the inhabitants of a certain area they are able to pick up the first signals of problems with certain individuals or families. E.g. psychiatric problems but also feelings of loneliness or alienation.

3. Safety Houses

The first Safety House started in 2002 and nowadays there is a nationwide network of regionally operating Safety Houses. Safety Houses are networks of local organizations working together to reduce crime. Criminal Justice Organizations cooperate with municipalities, social sector and care organizations to combine and integrate penal and rehabilitative interventions for offenders. They do not only collaborate, the partners in

Safety Houses also share the same office. This allows them to learn a lot about each other but also to learn how to trust each other. As organizational and physical distances are shorter, actions are taken earlier.

In Safety Houses the partners make specific agreements as to who will do what and when on the basis of a joint analysis of the problem, so that punishment and care are not opposed but rather reinforce each other. They have selected a number of categories of offenders who are systematically discussed at the Safety House: frequent offenders, robbers, members of delinquent gangs and criminal groups, systematic violent offenders, young recidivists, perpetrators of domestic violence and former prisoners with multiple problems. Often the Safety Houses are oriented towards certain families with multiple problems. Safety Houses have arranged that care is much more concentrated. This is also reflected in the slogan of Safety Houses: One Family, One Plan, One Director.

4. Covenant Police and Mental Health Care

Operational police staff regularly come into contact with civilians with psychological and/or addiction issues who cause inconvenience and (feelings of) insecurity. These are considered to be 'confused persons' who cause inconvenience, require assistance, languish, act dangerously or commit offences. The police estimates that they spend a considerable part of their capacity- that is about 13% - on this group of 'confused persons'. A reason for this is that the police are available 24 hours a day and therefore can be called upon at all times. In the police always chooses to act independently, or to (also) appeal to mental health care services (in Dutch: GGZ). Mental health care services can also call the police for assistance. In view of this reciprocal dependence, a good collaboration between the police and mental health care institutions is important. In order to facilitate this, cooperative agreements have been made in a covenant with police and mental health care.

The covenant is a national framework that is brought into practice regionally, so the execution of the covenant can differ regionally. In 2003 the police and mental health care services entered into the first national covenant. In 2012, a second police – mental health care covenant was drawn up.

In 2016 these covenants were evaluated. Among others this resulted in the agreement to pay more attention to prevention and signaling. Moreover they agreed to co-operate more closely in the emergency rooms by having psychiatric care officers working there too. These officers can select the need to offer psychiatric help more quickly. And there will be made arrangements to adapt the detention of psychiatric offenders to their specific needs.

E.g. in city of The Hague the police has arranged special cell units with staff from a mental health care institute providing for the needed care. After a person with psychiatric problems has been detained a public prosecutor decides on the criminal consequences while mental health staff assess the health situation. Together they start up an action plan for the person involved.

5. Case Veldhoven: a safety and security mark

In a small town in the south of the Netherlands, called Veldhoven, a big care organization for mentally disabled persons called Severinus is situated in two neighborhoods. In 2015 Severinus took the initiative to formalize the co-operation with municipality and police in a safety network. A working group consisting of professionals of these three parties agreed to co-operate on three themes, that is safety issues (like aggression, burglary, traffic, and fire alarm), social issues (like signaling loneliness) and livability (like loud noise and waste). The process was guided by a consultant of the Centre for Crime Prevention and Safety (CCV). The whole procedure was audited externally by another care organization. After approval the CCV gave the official mark "Safety and Care in the Area". Although co-operation was not new the success of it depended too much on the enthusiasm of individuals. And although a mark is not a guarantee for co-operation it has resulted in a better safety security awareness and policy within each organization.

6. Case Vught

In Vught the number of incidents with persons with a psychiatric background has reduced substantially due to two mental health nurses working in the community. The combination of their knowledge of the area and of the vulnerable people living there, and the knowledge of the operational police staff has resulted in early signaling and early care.

7. The Psycholance

People with psychiatric problems were often transported by force in police cars after incidents had taken place. Often this caused stress and aggression with patients as well as police staff. Since a few years there is the so called Psycholance. The Psycholance is a special ambulance for transporting people with psychiatric problems. From the outside it looks like a normal ambulance, but inside the design is more open and calming.

The Psycholance has several advantages for patients as well as for staff: patients need less restrictions and arrive more relaxed and more cooperative at the care institute while staff feels much safer.

8. Forensic psychiatry in the neighborhood

As more and more confused persons live in non-residential facilities, the organization of care and treatment has become outreached. Many so-called functional assertive community treatment teams have emerged that offer special intensive treatment at home for persons who have been of might become a risk to themselves or to others. They offer outreaching care and visit persons at home, offering matched care. These teams co-operate with other professionals working in the area, like police, neighborhood team and primary health care. In practice, cooperation in the chain of care is still difficult to the exchange of information about patients. Care professionals have the obligation of secrecy on what is told to them in trust. Experience has shown that good results can be obtained if police and care workers exchange internships.

A few lessons learned

Reducing aggression by people with psychiatric problems is a complex problem with many parties involved. It is not just a matter of care and safety. It is a complex network of intertwining measures directed at patients, their families, the communities they live in, the safety and care organizations and so on. In the Netherlands a number of initiatives has been taken and proven to be successful. A few lessons learned:

- It is not only about care and safety. Also other organizations responsible for the basic needs of persons with psychiatric problems, like income and housing, have to be connected. Organize a closed network of care around every patient.
- Organize collaboration at local level, but stimulate and facilitate this at national level. E.g. through a national taskforce that gathers all involved parties around the table;
- A better understanding of psychiatric problems by police staff through training and internships proved effective to reduce the use of force and to prevent aggression by psychiatric patients;
- Formalize the collaboration between care and safety in covenants and/or marks.
- Respect regulations but do not exaggerate. Encourage staff from care and safety organizations to find their common goals, that is to provide the right care to individuals and stimulate their and other persons' safety, instead of "hiding" behind formal rules and regulations.
- Involve persons with psychiatric problems and their families at all times
- Bridge the different working cultures of care and safety, e.g. by stimulating the exchange of safety and care staff, or by letting them share a working place.

Conclusion

Some severe incidents in the Netherlands have been a wake up call for care and safety organizations to co-operate more closely and to take signals of persons and their family seriously. Several initiatives have been undertaken to bridge the gap between these two professions. Although co-operation often is complicated by different working cultures, privacy rules and high fences within and between organizations, safety and care find each other more easily. With municipalities functioning as the binding glue at local level.

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Towards a Charta for collaboration between users and professionals

Keynote speech

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Violence in psychiatry has many faces. From a user perspective the psychiatric system could be violent in itself, because of changing personal stories of suffering into statistical means of disorders with concurrent standardized diagnoses and treatment categories. Because of limiting the scope to personal disorders instead of facing the lives of many with serious and disabling mental suffering. Could we find a way of bridging the gap between those facing violence in psychiatry from different kind of views? Could we find ways of bridging the gap between so called parties within psychiatry and find each other in multi-experiential solutions to all those dilemma's that concern all parties within psychiatry?

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The challenges of challenging behavior

Keynote speech

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Challenging behaviors manifested by persons with dementia include physical nonaggressive behaviors, such as pacing, verbal/vocal nonaggressive behaviors, such as repetitive requests, and aggressive behaviors, such as hitting or screaming. Aggressive behaviors are more common in late stages of dementia, when cognitive functioning is low. They are also more prevalent among men than among women. Aggressive behaviors are less common than nonaggressive behaviors. While these behaviors are relatively rare, they are very disruptive to care activities, and thus to the wellbeing of the person with dementia. Aggressive behaviors tend to be manifested towards caregivers, though they are sometimes directed at other persons with dementia. These behaviors often occur during help with activities of daily living and when the caregiver invades the personal space of the person with dementia.

Aggressive behaviors appear to result from a combination of discomfort and a sense of helplessness. The etiology is therefore an interaction between severe cognitive impairment which often results in difficulties in communication and a sense of helplessness, together with pain and discomfort, or fear of care activities which are incomprehensible to the person with dementia, or discomfort due to misinterpretation of reality. The aggressive behavior is more likely when the person tended to use a premonitory aggressive coping style. The aggressive behavior tends to initiate a vicious cycle where caregivers become wary of the person with dementia often resulting in more strict attitudes and less flexibility, further aggravating the aggressive behaviors.

Because these behaviors are not common, trials of nonpharmacological interventions for aggressive behaviors have not been conducted and are generally not feasible. Therefore, several case studies will be presented. These case studies demonstrate how the source of discomfort needs to be identified, and how all aspects of care need to be taken into account, in order to address the discomfort and the fears that are the triggers for the aggressive behaviors. The prevention of aggressive behavior will succeed only within an understanding of the person with dementia and environmental accommodation to the needs of that person. Conversely, environments that are not geared to provide for such needs fail in care of persons with dementia.

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Forms of neuro-cognitive dysfunction that increase the risk for violence

Keynote speech

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Introduction

Violence/ aggression is behavior involving physical force that hurts or damages an individual or object. A distinction can be made between aggression that is instrumental (i.e., directed towards a goal; e.g., mugging someone for their wallet) or reactive (i.e., a response to threat, frustration or social provocation) (Dodge, 1991). This distinction can be made on the basis of the neural systems that mediate instrumental and reactive aggression though it is important to note that this dichotomy is not absolute. Many psychiatric conditions are associated with an increased risk for aggression, particularly reactive aggression (e.g., borderline personality disorder and post traumatic stress disorder). However, disruptive behaviors, such as instrumental aggression and stealing are defining features of Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD) in youth and Antisocial Personality Disorder (ASPD) in adulthood.

The goal of this paper will be consider those neuro-cognitive systems that, when dysfunctional, increase the risk for aggression; i.e., those mediating "empathy", the acute threat response, reinforcement-based decision-making and response inhibition.

Empathy

Empathy is defined here as the response to the distress cues of others (their fear, sadness and pain). Neural regions that respond to emotional expressions include the amygdala, fusiform and superior temporal cortex (Fusar-Poli *et al.*, 2009). Emotional expressions both modulate on-going behavior and allow the rapid transmission of valence information regarding objects and actions (Blair, 2013).

Youth with conduct problems, particularly those with psychopathic or CU traits, show relatively selective deficits in expression recognition (Blair *et al.*, 2001). Recognition of fearful, sad and happy expressions is reduced while the recognition of disgusted and angry expressions remains intact (Dawel *et al.*, 2012, Marsh and Blair, 2007). Similarly, patients with CD, particularly when marked with psychopathic or CU traits, show reduced amygdala responses to sad (Passamonti *et al.*, 2010) and fearful relative to neutral (Marsh *et al.*, 2008, White *et al.*, 2012) expressions but no deficient responding to angry expressions. Notably, the level of decreased amygdala response to fear expressions relates to the level of CU traits shown by the child (e.g., Viding *et al.*, 2012, White *et al.*, 2012). Interestingly, studies have reported that elevated CU traits are associated with an increased risk for instrumental aggression (e.g., Thornton *et al.*, 2013). A recent study has shown that this association is mediated by the amygdala response to distress cues (Lozier *et al.*, 2014). In short, reduced responsiveness to the distress of others is associated with symptoms of reduced guilt, lower empathy and increased levels of instrumental aggression.

Acute Threat Response

Mammalian species show a graded response to threat; from freezing to flight to reactive aggression as the threat grows more proximal (Blanchard *et al.*, 1977). This response is mediated by the amygdala and its connections through hypothalamus to the periaqueductal gray (Coker-Appiah *et al.*, 2013, Mobbs *et al.*, 2010). The more proximal the threat, the greater the activity within this system and the more likely that reactive aggression will be shown in response to this threat.

While youth with CD and high CU traits show reduced threat responses, it has been argued that elevated threat responsiveness is seen in a sub-group of individuals at increased risk for antisocial behavior but who show low CU/psychopathic traits (Crowe and Blair, 2008). In support of this suggestion, several recent studies have shown that youth with conduct problems but low CU traits show increased amygdala responses to social threats (e.g., Viding *et al.*, 2012). In addition, youth with CD and low CU traits show increased recruitment of the amygdala and periaqueductal gray when engaged in retaliatory behavior to another individual's provocation (White *et al.*, 2015). Moreover, increased amygdala responses to social threat are also associated with a heightened risk for reactive aggression (Choe *et al.*, 2015).

Reinforcement-based Decision-making

There is a considerable animal and human literature on reinforcement-based decision-making (see O'Doherty, 2012). Ventromedial frontal cortex and striatum have been implicated in representing the reward value of potential response options and received reinforcements (Clithero and Rangel, 2014). The individual will approach objects/ initiate actions that are associated with positive reinforcement expectancies. If more than one response/object is available, ventromedial prefrontal cortex represents the values associated with these different responses/objects and dorsomedial frontal cortex responds to the "conflict" associated with the different responses/objects (Blair *et al.*, 2006). This conflict will activate attentional resources, via lateral frontal and parietal cortices, and response control resources, via inferior frontal cortex and anterior insula cortex, so that the optimal response can be selected (Budhani *et al.*, 2007). There also appears to be a role for anterior insula cortex, dorsomedial frontal cortex and striatum perhaps particularly in avoidance behavior (Budhani *et al.*, 2007, Kuhn and Knutson, 2005).

Considerable data supports the suggestion of dysfunction in reinforcement-based decision-making in youth with CD (Budhani and Blair, 2005, Fairchild *et al.*, 2009, Fisher and Blair, 1998). It appears that this dysfunction in reinforcement-based decision-making can be broken down into at least two computational processes: (a) reduced reward sensitivity; and (b) avoidance responses:

- (a) *Reduced reward sensitivity*: Reduced reward sensitivity/ responsiveness should result in an individual who makes poorer decisions. Their response choices will be less well guided by expectations that an action will result in reward relative to punishment. Such an individual is more likely to be impulsive. In addition, they are more likely to become frustrated; their actions will be less likely to achieve their goals (Blair, 2010). Increased frustration is associated with increased reactive aggression (Berkowitz, 1993). Youth with CD show reduced neural responsiveness to reward within both striatum and ventromedial prefrontal cortex (White *et al.*, 2013).
- (b) *Dysfunction in the systems implicated in avoidance behavior*: This dysfunction should result in an individual who is more likely to make inappropriate behavioral choices. Youth with conduct problems show less recruitment of anterior insula and dorsomedial frontal cortex when making suboptimal choices as a function of expected value (e.g., White *et al.*, 2013). This dysfunction may be specifically associated with an increased risk for antisocial behavior (White *et al.*, under revision).

"Instrumental" reactive aggression

As noted above, reactive aggression occurs following strong activation of systems mediating the acute threat response (the amygdala, hypothalamus and periaqueductal gray) by threat, frustration and social provocation. Reactive aggression is usually thought of as an automatic response to these provocations. However, it is clear that many examples of reactive aggression have a planned component. Indeed, this is implicit in the principle methods by which reactive aggression has been studied; the Taylor Aggression Paradigm (TAP; Taylor, 1967) and the Point Subtraction Aggression Paradigm (PSAP; Cherek *et al.*, 1997). These tasks index a participant's level of chosen retaliatory behavior, associated with anger, to a provocateur; the participant selects a level of retaliation via button press; i.e., the task indexes instrumental retaliation.

Importantly, if tasks such as these involve instrumental choices then they should recruit regions implicated in representing the value of behavioral choices. This is the case (White *et al.*, 2015). Increasing levels of retaliatory behavior are associated with increasing activity within periaqueductal gray (White *et al.*, 2015). At the same time, increasing levels of retaliatory behavior are associated with increasing costs to the aggressor, and this is associated with decreasing activity in ventromedial prefrontal cortex (White *et al.*, 2015). A healthy individual may still decide on a measured retaliatory response despite representing the cost because of their anger at the provocation towards them. However, an individual whose ability to represent the costs/benefits of their actions is compromised, is less likely to show a *measured* retaliatory response. They will be impaired in representing the costs/benefits of their response and thus more likely to engender a disproportionate

retaliation. Individuals with CD show disproportionate retaliations to provocation (White *et al.*, 2015). Their propensity for retaliation relates to the level of compromised ventromedial prefrontal cortex activity (White *et al.*, 2015). Moreover, propensity for retaliation and level of compromised ventromedial prefrontal cortex activity predict levels of reactive aggression shown by the participants (White *et al.*, 2015).

Response Inhibition

Response inhibition is considered a core executive function (Friedman and Miyake, 2004) and has been related to measures of task switching ability, executive control and the ability to produce non-stereotyped responses (Friedman and Miyake, 2004). The core neural systems involved in response inhibition include inferior frontal gyrus, anterior insula cortex and dorsomedial frontal cortex (particularly the pre-supplementary motor area) (e.g. Aron, 2011, Meffert *et al.*, 2015). It has been argued that inferior frontal gyrus, anterior insula cortex and pre-supplementary motor area “work together to send a Stop command to intercept the Go process, via the basal ganglia” (p. e56; Aron *et al.*, 2011).

Impaired response inhibition appears to be a risk factor for antisocial behavior. For example, Miyake, Friedman and colleagues found that a common executive function/inhibition variable was substantially correlated (- 0.63) with a behavioral variable corresponding to a variety of externalizing behavior problems, including attention deficits (often shown by individuals with ADHD, CD, and substance use) (Young *et al.*, 2009). The fMRI literature has been less conclusive. Three studies of CD reported intact behavioral response inhibition and no group differences in recruitment of regions implicated in response control (Banich *et al.*, 2007, Rubia *et al.*, 2009, Rubia *et al.*, 2008). A fourth study reported decreased right but increased left inferior frontal gyrus/ anterior insula cortex activity in patients with ODD relative to controls during performance of a Go/Stop task (Zhu *et al.*, 2014). However, it is worth noting that three of these studies were careful to exclude patients with CD with comorbid ADHD. As such they may have excluded those patients with CD who would show impairment in this function. A fourth study did observe reduced recruitment of anterior insula cortex in the patients with CD during incongruent relative to congruent trials on a Stroop task (Hwang *et al.*, 2016). However, extent of impairment related to ADHD symptomatology not severity of conduct problems. Indeed, patients with ADHD, particularly those who display motor disinhibition, show significant impairment on measures of response selection such as the Stroop task, the Stop task, and Go/No-Go (Pennington and Ozonoff, 1996). In addition, studies have frequently documented reduced recruitment of these regions during the performance of these or similar tasks in patients with ADHD (e.g., Rubia *et al.*, 2009). In short, dysfunction in the neural systems mediating response control does appear to be present in many individuals who meet diagnostic criteria for ODD/CD and likely exacerbates their symptomatology. However, the primary behavioral consequences of response control dysfunction are the symptoms associated with ADHD.

Conclusions and Co-morbidities

In the current review, we primarily considered fMRI data regarding neuro-cognitive mechanisms that are dysfunctional in patients with CD/ODD and, when dysfunctional, increase the risk for aggression.

We considered empathic processing and, more specifically, the neural systems that respond to the distress cues of other individuals and use this information to both modulate current behavior and to associate consequent negative valence with objects/ actions being performed in the environment. Level of dysfunction in this neuro-cognitive system relates to level of CU traits and increases the risk for instrumental aggression.

We also considered the neural systems engaged in the acute threat response (amygdala, hypothalamus, periaqueductal gray). Youth with CD and low CU traits show *increased* amygdala responses relative to healthy youth (Viding *et al.*, 2012). Level of amygdala response is positively associated with propensity for reactive aggression (Choe *et al.*, 2015).

An additional two mechanisms (reinforcement-based decision-making and response inhibition) show no clear relationship with level of CU traits. However, both are associated with increased levels of impulsive, and potentially antisocial, behavior (Hwang *et al.*, 2016, Plichta and Scheres, 2014). Both are particularly interesting with respect to the high comorbidity of CD/ODD with both ADHD and substance abuse. ADHD is associated with dysfunction in both systems (Plichta and Scheres, 2014).

To summarize, we discussed several neuro-cognitive systems that are impaired in CD/ODD and increase the risk for aggression. Importantly, none of these forms of impairment are exclusive to patients with CD/ODD. Even dysfunction in the response to distress cues, a definitional impairment to the subset of youth with CD/ODD and CU traits, can be seen in a minority of aggressive patients with autism and schizophrenia. Adequate

assessment of the functioning of these mechanisms at the level of the individual should provide far greater detail regarding treatment targets for the individual than the standard diagnostic approach. A main goal now will be to develop interventions that specifically address these forms of dysfunction.

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ICN Position statement on violence

Keynote speech

Frances Hughes

CEO International Council of Nurses - ICN

Abuse and violence against health personnel is an existing and widespread problem in developing and transition countries as well as the industrialized world and nurses are a category of worker particularly at risk. The International Council of Nurses (ICN) strongly condemns any forms of violence against nursing personnel that violates the nurse's rights to personal safety, dignity and respect and freedom from harm. Protecting all healthcare workers and promoting safe working environments has been an ICN priority for many years and the ICN position statement, which is currently under review, is the principle document informing ICNs campaigning and policy work. Frances Hughes, ICN CEO, will describe the continuum of abuse and violence that nurses can be exposed to in the workplace and the work to review and update the ICN position to reflect the reality of current nursing practice. ICN firmly believes that violence in the health workplace threatens the delivery of effective patient services and Frances will outline strategies and approaches to mitigate and eliminate harm to staff and ensure improved outcomes for patients.

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From conflict, through peace process, to reconciliation

Keynote speech

Geoffrey Corry

Dialogue Facilitator at the Glenree Centre for Peace and Reconciliation, Co Wicklow, Ireland

Abstract

The political violence that lasted for thirty years in the Northern Ireland ‘Troubles’ (1969-1994) was partly driven by powerful emotional narratives on both sides that brought together a lethal cocktail of religion, ethnicity and political crusade. These narratives mobilised and radicalised a generation of young armed actors in 1972 who joined on one side the Provisional IRA after the atrocities of Bloody Sunday in Derry and on the other side the Loyalist paramilitaries (UVF and UFF) after Bloody Friday in Belfast. Through the lens of the “bottom-down” process of the Peace Pyramid and the work of political psychologist Vamik Volkan, we can better understand these huge deeper forces at work. If those narratives are not transformed in this generation in the light of the suffering that the violence brought, then they have the potential to come back to destabilise the peace in the next or future generations. Let us not ask our kids and their children carry the pain.

But how did civil society people, political leaders and governments interrupt the cycles of violence so as to get out of protracted inter-communal violent conflict? When conflict zones around the world look at the Northern Ireland peace process, they get inspiration and hope from the way in which the ‘terrorists’ were brought into an inclusive political process and voluntarily put away their arms. Three sequential phases of a peace process are identified [red zone of engagement, blue zone of resolution and yellow zone of implementation]. Crucial to the success of the peace process was the way in which a succession of political leaders and civil servants in Britain and Ireland became committed over a sustained period of twenty years to reach the goal of an inclusive and comprehensive negotiated agreement. The doves succeeded in drawing the hawks into a political process instead of putting state resources into a military solution.



It is now almost twenty years since the masterly crafted compromise of the Belfast/Good Friday Agreement (1998) brought an end to the conflict. Yet it has only recently become possible for many victims/survivors to talk outside their family circle about what happened and for political parties to work with the legacy of inter-communal violence. Some prefer to stay with the silence and forget about the past. To date, there is no political agreement on legacy structures and over fifty inquests about legacy killings (which can provide a modicum of justice to victims) remain to be processed because of the lack of dedicated financial resources.

Such impasse does not help the healing of inter-communal division. Emotional pain and trauma continue to block many victims/survivors from leaving the past behind, to move on and to take an active part in shaping not only the present but also the future. After all, the past is meant to be learned from, not lived in.

Glencree Centre for Peace and Reconciliation has pioneered a residential two-day large circle workshop that enables victims/survivors to tell their story in the presence of other significant parties to the conflict. In these interactive encounters, opportunities for acknowledgement, dialogue and apology can arise that can, over time and through additional encounters, bring about emotional healing and long term inter-communal relationship building. They are enabling victims and ex-combatants on both sides to work through the horrific impact of political violence, the suffering it caused, and hopefully arrive at some new collective understandings sufficient to shift the old local and national narratives. Release from the past for many victims comes through struggling to understand why people resorted to political violence in the first place, to affirm the sanctity of life and to ensure that violence will never be used again to achieve political goals.

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Chapter 2 – Special workshops

The Choreography of Catharsis: Recognizing, Responding, and Recovering from Violence in the Health Sector

Special workshop

Patricia P. Capello (USA)

Even before birth, human beings are sensitive to cues from their environment and respond to them on a body level. As we grow, our senses develop and are refined by both our physical surroundings and our emotional and relational connections to others. The “intuitive self” can access vital nonverbal cues that can be used to assess the world and people around us.

By practicing the basic constructs of DMT (dance/movement therapy) individuals can begin to hone the natural skills that are present in everyone. DMT exercises in attunement include elements that are fundamental to the health care professional: awareness of body position; body boundaries; engagement and disengagement on a body level; and the non-verbal communication of the physical self.

This experiential workshop will help participants recognize informational sensations in their own bodies and develop a kinesthetic empathy and awareness of those in others. Through practice of the movement elements of flow-weight-time-space, our responses to interpersonal situations (both aggressive and non-aggressive) will be better understood and regulated. Finally, exercising the body’s innate recuperative abilities by exploring the power of breath, tension-relaxation, and strength, participants will learn how to activate their own recovery from incidences of violence.

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Where care and safety meet

Special workshop

Bernadette Schomaker, Peter Peerdeman

Centre for Crime Prevention and Safety, Utrecht, and CAOP, Den Haag, the Netherlands

The workshop “Where care and safety meet” will be based on and connected with the keynote address by Bernadette Schomaker & Peter Peerdeman (see page 38). However in this interactive workshop the subject will be explained in more detail and exemplified with reference to the practice of the program in the Netherlands.

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Special workshop on mindfulness

Special workshop

Sheena Clarke (Ireland)

Sheena is a Residential Social Care Manager for children in residential care with more than twenty years experience working in the Health Service Executive and the national Irish Child & Family agency. Sheena has completed a BSc in PMAV (Professional Management of Aggression and Violence) in 2009, and a Diploma in Mindfulness Based Interventions in 2016.

She provides an eight week Mindfulness Based Stress Reduction programme for healthcare staff within the Child & Family agency and believes that it is vital that health care services invest in the people that deliver care to the most vulnerable.

The average person is on 'autopilot' 47% of the time, with our attention absorbed in 'wandering' minds and not really 'present' (Harvard Gazette, 2010). Mindfulness is a method of improving our attention to the present moment without judgement. (Kabat-Zinn 1990). Numerous studies have demonstrated the benefits of mindfulness in supporting individuals to live more authentically and with improved kindness and compassion. Empirical evidence over the last 30 years has supported the positive impact of Mindfulness Based Stress Reduction (MBSR) and/or Mindfulness Based Cognitive Therapy (MBCT) on improving mental health, individuals' experience of pain, brain function and general well-being (Williams, 2011).

Zylowski et al. (2007) suggest that Mindfulness has emerged as a new approach for stress reduction and an important innovation in treating psychiatric disorders. Mindfulness programmes are now employed as an adjunct in the treatment of many disorders including addictions, eating disorders, chronic pain, anxiety, borderline personality disorder, and in relationship enhancement.

Evidence suggests the positive effects of mindfulness on brain functioning, managing day-to-day stress, irritability and anxiety, and in preventing depression. Those who use mindfulness regularly have demonstrated improved attention, memory and faster reaction times, with positive effects also on medical conditions including hypertension, immune system functioning, cancer and chronic pain (Williams, 2011). Recent developments within neuroscience, investigating the plasticity of the brain, suggest, that mindfulness training can alter the functioning of the areas of the prefrontal cortex associated with mood and happiness (Davidson 2012).

This workshop will present a practical mindfulness session and explore how delegates might employ mindfulness in becoming more mindful in their daily life.

Previous participants have suggested that "Caring for our own wellbeing is crucial"; "Being with my own thoughts feels so liberating" and that "I have learnt to appreciate my own life in this moment".

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Creating a 'living' position statement on violence in healthcare

Special debate

Howard Catton (Switzerland) and Kevin McKenna (Ireland)

This highly interactive workshop will explore the preparation of an informed position paper which addresses all manifestations of abuse and violence in healthcare workplaces, that can be used by stakeholders at multiple levels.

The workshop will consider the three core concepts of 'authenticity', 'utility' and 'relevance'. The interactive exploration of each of these core concepts will demonstrate the process by which it is possible to develop a substantive position which can cross the theory/practice divide.

Specifically the workshop will explore how to engage frontline staff to ensure the position statement reflects the reality of their practice and daily working lives, is evidence and values based, and can be used by organisations such as National Nursing Associations to influence policy and political decision makers.

Learning Outcomes:

1. Participants will have the opportunity to broaden their understanding of the role purpose and function of a position statement in relation to aggression and violence within healthcare settings.
2. Participants will have the opportunity to understand the dynamic process involved in creating a position statement that is real, meaningful, useable and effective.

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Chapter 3 – Aggression and/or violence toward staff or service users

This chapter encompasses presentations on the following sub-theme of the conference:

- Aggression and/or violence toward staff or service users
-

Aggressive behaviors and risk of violence in Cape Vert's psychiatric setting

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Risk assessment, violence, patients, psychiatry

Risk assessment of violence allows the selection of appropriate interventions for prevention and control of aggressive behaviors.

Objective

Identify the pattern of aggressive behaviors, evaluate the dynamic predictors of violence of hospitalized patients, in the Psychiatry Department at Agostinho Neto Hospital.

Method

An exploratory study was conducted during approximately six months. We used The Broset Violence Checklist (BVC) (Almvik & Woods, 2003) and the Staff Observation Aggression Scale-Revised: SOAS-R (Nijman *et al.*, 1999).

Results

51 aggressive behaviors were observed in 40 patients, with the following characteristics were: verbal aggression behaviors, precipitated by other patients and by denying something to patients by professionals, developed against professionals and other patients whose consequences were centered on people causing feelings of threat. 34 patients had low risk of violence and the most observed predictors were: confusion, irritability and anger.

Conclusion

It is important to prevent the phenomenon of violence in psychiatric settings to promote a more therapeutic and safer environment. This is an area of competence of nurses and expert in mental health that needs to be further researched.

Learning objectives

Participants will learn about...

1. patterns of aggressive behaviors of hospitalized patients, in the Psychiatry Department at Agostinho Neto Hospital.
2. the identification of the dynamic predictors of violence of hospitalized patients in the Psychiatry Department at the Agostinho Neto Hospital.

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Hospital and Union Partnership to Advance Workplace Violence Prevention: Optimizing and Evolving Staff Safety Pendants

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Southlake Regional Health Centre, Newmarket, Canada*

Keywords: Workplace Violence, Prevention Tools, Partnership, Staff Safety Pendants, Code White, Code White Response System/Team

Background

Southlake Regional Health Centre is committed to a Culture of Safety. In 2013, a serious workplace violence incident occurred at the hospital; members of the Southlake team were injured by a patient surfacing concern across the organization and with union partners. A Workplace Violence Prevention Committee was created. The Workplace Violence Prevention Committee created a forum for internal/external stakeholders and experts to come together to support a culture of safety and change with a focus on the prevention of injuries. This abstract will highlight the partnership journey between the Ontario Nurses Association and Southlake Regional Health Centre outlining the key success factors while focusing on the quality improvement journey of developing effective staff safety pendants.

Quality Improvement Journey of Staff Safety Pendants

In June 2013, a review of personal safety devices, associated infrastructure and safety measures and procedures was initiated. In August 2013, Staff Safety Pendants were issued to staff hospital-wide utilizing the existing RTLS system. Swift implementation of the Pendants occurred and offered added protection without the additional costs and lag-time associated with a new enterprise-wide implementation. In September 2013, the Staff Assist Steering Committee was established. The number of inadvertent button pushes was a concern. To address the concerns, the organization worked with the vendor to modify the pendant. To date a total of 4 modifications have been made, each decreasing the number of inadvertent button pushes in comparison to the previous version.

Methodology

In 2015, the Staff Safety Steering Committee was tasked with a complete review of the staff safety system solution. In order to assess the effectiveness of the tool/pendant, a pilot was developed. The pilot took place from August 1, 2015 through December 31, 2015 including a total number of 3465 safety pendants across the organization of which 600 were introduced as version 5. Therefore, 17.3% of implemented pendants were version 5 for the pilot.

Organizational Staff Safety Pendant Version Comparison

Data related to utilization of the version 5 pendants broken down by intentional and inadvertent pushes from August through December 2015 shows that: Overall there were 72 activations of version 5 pendants: 63 were intentional (87.5%), and 9 (12.5%) were inadvertent. In comparison, during this period the total number of organizational activations for version 1 – 4 was 723: 136 (18.8%) were intentional and 587 (81.2%) were inadvertent.

Findings

Key Findings for the Staff Safety Pendant Pilot of Version 5:

1. Overall inadvertent pushes (Average # of pushes per month/# of users) decreased from a monthly average of 5.4% for version 1 - 4 to 0.3 % for version 5.
2. There is a marked difference between version 1- 4 and version 5 effectiveness related to inadvertent push performance.

3. Version 1 - 4 inadvertent activations have decreased, however, remain at an unacceptable level.
4. A T-test analysis did not demonstrate a statistically significant difference between pre and post version 5 implementation, however, a marked decrease in inadvertent pushes was found.
5. The risk of continued inadvertent activations of approximately 10/month can be expected following the migration of all users to version 5.

Implications

Key Success Factors include: Senior Level Hospital Leadership Engagement (CEO and Executive); Senior Level Union Leadership Engagement (Provincial and Local); Workplace Violence Prevention Committee; Joint Health and Safety Committee Consultation; Identification Organizational Workplace Violence Scorecard; Strategic Partnerships; Fact and Evidence Based Approach

Learning objectives

Participants will...

1. be able to understand a partnership approach in a quality improvement initiative supporting a safe work culture.
2. have an understanding of the effectiveness of an evidence based approach in evolving to a safe work culture.
3. be able to identify key success factors for implementation of safety initiatives.

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Applying the process of client engagement to reduce workplace violence in health/social care settings

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Engagement, violence, education, management, supervision, training

Introduction

Engagement with clients is viewed by health professionals as being a key component in reducing workplace violence within the health sector. Yet the actual means to achieve engagement with clients who may be challenged in their social relationships is challenging and this aspect of providing care is often overlooked or taken for granted in clinical practice.

If health care professionals do not feel that they have been adequately trained to engage with the client they will feel reluctant to do so, particularly in an environment where engagement is not the norm, not encouraged or is absent. This builds a lack of confidence and reluctance in professionals in carrying out engagement activities, particularly if management is not rigorously promoting and enforcing the use of engagement activities. It is anticipated that as health educational institutions and health care settings work in partnership to build, develop and maintain engagement skills in health care professional the potential for violence in the health care sector will help to be minimized.

Engagement

On reviewing the literature on this topic one is struck by the fact that the term “engagement” has two distinct meanings. Firstly, within clinical practice, it is used to engage with the client in moving towards clinical goals. Smith et al (2010, p1) note that engagement in care is defined as “developing a trusting relationship between the treatment team and the individual.” Secondly the term “engagement” is used in the wider organizational psychology sense of engaging in the work environment to achievement a sense of fulfillment within the work environment. Therefore, for professionals in clinical practice, the term engagement can have a clinical or an organizational meaning.

This then presents something of a conundrum when looking at the use of the term “engagement” in clinical practice. Health care professionals may engage with clients to help them move towards successful clinical outcomes, and are therefore engaged clinically, and in so doing they are more fully engaged in their professional role and are therefore achieving a level of job satisfaction that can be both expressed and measured. In short, engagement with clients assists the professional in becoming engaged in their work role.

This form of engagement in work role is recognized as being the desirable end of a spectrum within the organizational psychology of professions that has burnout at one end of the spectrum and engagement at the other end of the spectrum (Leiter and Maslach 2005). In this sense, engagement is defined as “an energetic state of involvement with personally fulfilling activities that enhance one’s sense of professional efficacy” (Maslach and Leiter 2008, p498). Although within the literature on the organizational psychology of professions, much has been reported and written about regarding burnout, very little has been written about engagement. What we do know is that having professionals that are engaged in their job helps them to avoid burnout and provides them with a level of satisfaction that should assist in promoting retention.

Engagement as a clinical tool

Engagement in the job for health sector professional should, by the very nature of the job, involve engagement with the client. Professionals have to be engaged with clients to assist them in achieving desired health outcomes. However, as we know from our clinical experience, frequently the client themselves are not engaged in the process of their own recovery and this presents a challenge in their care and treatment. How do we become engaged with a client who does not want to become involved in their own recovery? The

challenge should be met with the health care professional using her/his therapeutic skills to come alongside the client and engage with them in the recovery process. Approaches such as Trauma Informed Care (Hopper et al 2010) and the Tidal Model employed by Barker (2001) place emphasis on the use of therapeutic skills and active engagement with the client. Typical of models focused on engagement with clients, the Tidal Model is a holistic approach to care that promotes the exploration of the client's narrative to encourage the client's greater involvement in the decisions affecting their assessment and treatment.

Polecek et al (2015) outline the benefits for professionals in being clinically involved with the client as they move towards clinical treatment goals whilst being engaged in one's work to achieve professional fulfillment. This involves making a connection with the client for the professional to accept, understand and tolerate what is "normal" for the client as they engage with them on a one-to-one level. This supports the notion of Cutcliffe and Barker (2002) that the process of engagement involves forming a relationship; making a human-human connection; conveying acceptance and tolerance; and hearing and understanding. Therefore, a lack or failure in the engagement process would imply that a professional has failed to form a relationship with the client; not made a human-human connection; failed to convey acceptance and tolerance and does not hear or understand the client.

The foundation of this lack of engagement is appears to be built upon

- a. Lack of education
- b. Lack of confidence
- c. Lack of supervision

Confidence in engaging with clients is built upon education and practice in the skills of being involved with them, and the supervision and promotion of these skills in clinical practice.

Educational elements

From the issues thus far examined, a picture of engagement builds up whereby engagement with clients is based upon the four components of i) commitment, ii) dedication, iii) listening and encouragement, and iv) the use of a partnership model for problem solving and decision making. Through the implementation of these components health sector professionals can develop cultural sensitivity and an ability to empathize with the client and speak their language. The ability to develop this range of tools to be utilized in engagement is dependent upon clinical supervision and a commitment to ongoing education in the clinical arena.

Therefore in terms of constructing educational experiences for teaching students concepts involved in engaging with clients the educational process has to include:

1. Commitment from the student to become involved with the client. This has to be demonstrated in class, through role play and simulation, but also in clinical experience and as a foundation for their role as a health care professional.
2. Dedication to engage with clients must be realized by the student in the knowledge that some clients do not wish to become engaged with health care professionals. Students must demonstrate consistency in approaching the client and the application of therapeutic skills
3. To do so students have to develop a range of therapeutic and communication skills. These are delivered theoretically in class but the skills involved are developed through practice in class, role play, clinical simulation and the development of skills in clinical laboratories as well as in supervised clinical practice
4. The delivery of the engagement process with clients can best be realized if the practitioner is practicing within an environment where a partnership model of care is provided. Therefore the student has to be taught the various approaches to partnership models of care and exposed to these models if possible. Knowledge of these models provides a frame of reference for when the student moves into professional practice.

The aim of student assessment should therefore contain an element of ensuring that the student is knowledgeable and experienced in the skills of client engagement. Smith et al (2010) note that strategies for enhancing engagement with clients can be implemented without any for an "extraordinary commitment of resources" (p1). Indeed, it could be argued that the resources exist already in clinical areas but they are not being activated or employed correctly, and lack of such engagement with the client can contribute to burnout which is a major concern for any organization.

Management Elements/Violence Prevention Program

As students make the transition from academia to the clinical environment and from novice to expert, authentically engaging with patients may unconsciously take the backseat to the tasks of caring for the patient. This is especially true in the emergency department or on non-psychiatric units of a hospital where the focus of training and education is through the lens of stabilizing medical problems. Organizational strategies should include mandatory violence prevention training for all staff (Occupational Safety and Health Administration (2015) since all staff are at risk (Phillips, 2016). The Occupational Safety and Health Administration (OSHA) offers a framework for a violence prevention program that includes:

1. Management commitment and employee participation
2. Worksite analysis
3. Hazard prevention and control
4. Safety and health training
5. Recordkeeping and program evaluation.

Education delivered in the clinical environment must take into account approaches to de-escalate crisis that will support staff by providing a model that can be easily articulated among staff. Without a clear and systematic description of a model, when staff are confronted with violence they may react inappropriately. While there are many training programs, it may be that finding a generalizable model that can be applied to all staff roles and all situations can help staff apply knowledge to practice.

One such de-escalation model is described by Bowers (2014) and similar to other models that propose defining stages or levels of crisis and suggesting interventions that are rational and effective. Interventions should include both interpersonal and environmental components that take into account the immediate safety of all persons while maintaining self-control and communicating empathy and respect. If an organization relies solely on a third party curriculum, costs may restrict the number of staff who receive training. Perhaps a sustainable violence prevention and de-escalation training program could be a combination of a third-party curriculum and a less intensive curriculum developed by in-house educational staff relying on evidence based principles.

A comprehensive program that supports all staff roles, care environments, and the many scenarios and populations can not only prevent violence and injuries, but as outcomes improve, so will the relationship between the organization and their customers. Unique situations require unique preparation such as suicidality (Cutcliffe, & Barker, 2002), an aging population (Bartels, & Naslund, 2013), delirium, traumatic brain injuries, and dementia. A successful violence prevention program demonstrates the authenticity of organizational engagement to the community.

If health care professionals do not feel that they have been adequately trained to engage with the client they will feel reluctant to do so, particularly in an environment where engagement is not the norm, not encouraged or is absent. This builds a lack of confidence and reluctance in professionals in carrying out engagement activities, particularly if management is not rigorously promoting and enforcing the use of engagement activities. One way that organizational leaders can communicate that they are engaged is to establish a period evaluation program that takes a close look at the work environment and processes. For example, the emergency department environment experiences high rates of violence (Kowalenko, *et al.* (2012) requiring clinicians to provide complex medical and psychiatric-mental health care in a constant state of alert. A team of clinicians that includes a nurse, a CNA or Tech, and a security staff can periodically conduct a safe environment evaluation that takes into account human and physical factors. By actively supporting such safe environmental assessments and immediately enabling quality improvements, leadership will be perceived as putting their money where their mouth happens to be.

Anyone with responsibility for managing clinical nursing staff must have the confidence and experience to promote engagement with clients. There is therefore perhaps a need for training and orientation in these activities for managers as well as clinical staff. Smith et al (2010, p2) note that "it is critical to develop well-trained staff and that experienced, committed staff are more effective at engaging and retaining clients in care." Facilities providing psychiatric/mental health services must therefore be committed to training and developing staff in engagement with the clients. Smith et al go on to point out that best-practice providers offer clinical supervision for staff along with on- and off- site continuing education activities and it is worth putting forward this combination of supervision and continuing education as a model for developing and maintaining engagement as a clinical component. At the very least, engagement in the clinical setting should involve the "universal engagers" of the professional speaking the same language as the client and demonstrating cultural sensitivity towards the client (Smith et al 2012, p2).

Conclusion

Engagement with clients has been demonstrated to be an effective means of reducing workplace violence as well as contributing to job satisfaction for health professionals. For engagement to be successful it must be taught, encouraged and assessed in students across the health care sector. The teaching of students on its own does not ensure that engagement with clients will be a reality in practice, the skills learned as a student must transition into clinical practice. For that to happen engagement with clients must become part of the norm, and the expectations, in clinical practice. This involves health care institutions having a comprehensive approach to dealing with violence reduction that includes not only on-going training in engagement techniques but also in the promotion, supervision, and assessment of engagement in client interactions. Leadership can demonstrate engagement by taking safe working environments as seriously as regulatory compliance. Engagement is a resource that can often be ignored or downplayed in professional training and clinical practice, for it to be an effective resource for health professionals it must be given prominence as a clinical tool in education and practice

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Learning objectives

Participants will...

1. have an understanding of how education and management are partners in promoting client engagement and reducing workplace violence.
2. be able to outline strategies that they can employ in educational or clinical settings to promote client engagement.

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Safeguarding within female forensic mental health pathways: Promotion and development of Positive Culture of Safeguarding in the management of safeguarding incidents

Sub-theme: Aggression and/or violence toward staff or service users

Workshop

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Keywords: Violent offenders, female mental health, safeguarding issues, proactive relationships planning

Background and context

The focus of this paper is safeguarding management of incidents within Women's mental health services. The paper will describe types of management of complex safeguarding incidents with mental health settings over a period of 2 years. The proactive safeguarding measures /planning interventions include types of safeguarding incidents and safeguarding protection planning. The umbrella term "safeguarding" as developed significantly since the emergence of statutory obligations of organisations to ensure that all vulnerable adults are appropriately protected whilst under their care. This has steadily derived and evolved from legislation since 2006, and in response to Winterborne View and Mid Staffs NHS failings and findings. Mental health services have been increasingly scrutinised in terms of keeping people safe in an in-patient setting. Due to the large population of mental health service users in our Women's Service treatment and care pathway there is a complex range of safeguarding Issues. The purpose of putting together this paper is to endeavour to share our findings on types of complex incidents and the management of these whilst also looking at the process of reflecting on safeguarding incidents and learning lessons in a continuous improvement cycle.

Methodology

The service users were predominately forensic mental health service users detained under the MHA 1983 (as amended by MHA 2007). All were female in-patients in medium secure, low secure and open ward environments, with multiple diagnosis and complex needs. As a social work team we reviewed the amount of safeguarding incidents over a two year cycle. This included recording when all incidents took place and the management plans in place following safeguarding incidents. This was recorded contemporaneously onto a database that we formulated (safeguarding log) and also on our main electronic records database. We collated this data in the form of graph to show the statistical amount of incidents, type of abuse etc. from 2014 -2016. The reason why we chose the data is because it demonstrates the number of incidents and fluctuations due to bed occupancy and service development.

Findings

Various methods of management of complex safeguarding incidents are employed, for example as proactive individual relationship safeguarding plans were successfully formulated in response to previous lesson learned, which resulted in positive outcomes. These included reduction of incidents for certain prolific safeguarding incidents and also the focus of positive, and safe management of relationships between service users taking into account risk and human rights. Case studies will be presented and discussed to illustrate types of safeguarding incidents and ways of proactively working with a person to minimise harm safely.

Implications for practice

There are many considered "grey area" types of management of safeguarding practices that we implemented that could inform other services. Particularly the safeguarding interventions around relationships between service users and sharing best practice of what works well/lessons learnt. Furthermore the safeguarding practices around working with women in secure mental health setting with forensic background would be of key interest to other services.

Learning objectives

Participants will...

1. learn about innovative and creative safeguarding practices being implemented within a female mental health setting.
2. learn how to implement proactive relationships planning between service users to managing more effectively managing violent and repeat offenders.

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As Time Goes By: Reasons and Characteristics of Prolonged Episodes of Mechanical Restraint in Forensic Psychiatry

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Aggression; forensic; restraint; risk assessment; risk management

Background

Evidence suggests the prevalence and duration of mechanical restraint are particularly high among forensic psychiatric inpatients. In Denmark, time spent in mechanical restraint is increasing, despite a requirement for a 50% reduction by 2020 by the Ministry of Health in 2014. Danish figures show that duration up to 48 hours increased from 4,558 episodes in 2011 to 5,283 episodes in 2013 and duration above 48 hours increased from 675 to 882 episodes (Gildberg *et al.* 2015, SST 2014). In the Region of Southern Denmark, duration greater than 1 week has increased from 3.3% in 2008 to 6.4% in 2011. However, a recent literature review on mechanical restraint in forensic psychiatric inpatient settings does not consider prolonged use (Hui *et al.*, 2013). Accordingly, the length of time spent in mechanical restraint still appears to be based on custom and practice rather than clinical criteria (Walsh & Randell, 1995). Consequently, little is known regarding the characteristics and reasons for prolonged use of MR.

Aim

This study therefore aimed to investigate prolonged episodes of mechanical restraint on forensic psychiatric inpatients.

Method

Documentary data from 3871 medical record entries were thematically analyzed.

Findings

Results show that the reasons for prolonged episodes of mechanical restraint on forensic psychiatric inpatients can be characterized by multiple factors: “confounding” (behaviors associated with psychiatric conditions, substance abuse, medical noncompliance, etc.), “risk” (behaviors posing a risk for violence), and “alliance parameters” (qualities of the staff–patient alliance and the patients’ openness to alliance with staff), altogether woven into a mechanical restraint spiral that in itself becomes a reason for prolonged mechanical restraint. The study also shows lack of consistent clinical assessment during periods of restraint. Further investigation is indicated to develop an assessment tool with the capability to reduce time spent in mechanical restraint (Gildberg *et al.* 2015).

Implications

Actions to reduce duration, especially prolonged MR, must be of common interest. Clinical decision making in regard to mechanical restraint is however multifactorial and complex, and from this study, attention should be drawn to the lack of clear and consistent use of assessment items to ensure uniform assessment of both risk behavior and the alliance parameter during MR. In light of these findings, it would be reasonable to seek to develop an assessment tool that takes confounding, risk, and alliance parameters into account as to whether MR should be continued on a short-term basis, for example, during every shift. Such an instrument could be part of structured clinical judgment, known as the third generation of risk assessment instruments (Gildberg *et al.* 2015).

Learning objectives

Participants will...

1. have an understanding of the scale of time spent in mechanical restraint in a Danish setting.
2. have an understanding of reasons and characteristics for prolonged time spent in mechanical restraint on a forensic psychiatric ward.

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Compassion Fatigue, Compassion Satisfaction, Perceptions of Safety and Experiences of Violence Among Emergency Department Staff

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Compassion Fatigue, Emergency Department, Violence, Safety

Background

Violence in healthcare is a widely recognized problem, particularly in emergency departments (EDs). In addition to being exposed to violence, ED workers experience high levels of compassion fatigue. No research is available investigating the relationship of compassion fatigue, compassion satisfaction, and perceptions of safety and exposure to workplace violence among ED employees. A better understanding of these complex relationships may offer insight into whether creating safer work environments can decrease compassion fatigue among ED workers.

Methodology

A cross-sectional design was used to survey ED staff members in a US Level 1 Shock Trauma center. The survey included questions regarding exposure to violence, perceived tolerance to violence, perception of safety at work, and whether or not exposure to violence is an expected part of the job. The Professional Quality of Life: Compassion Satisfaction and Fatigue v. 5 tool (Stamm, 2010) measured compassion fatigue (secondary traumatic stress and burnout), and compassion satisfaction.

Findings

A total of 147 people completed the survey. All shifts and disciplines were represented; 87% of respondents, including members of every discipline, reported exposure to violence within the past six months. Ninety-eight percent of respondents reported feeling safe at work and 64% agreed that violence was an expected part of their job. The majority of respondents (53%) did not report any of the violence they experienced.

Males reported significantly higher burnout than females ($p=.029$). Nurses with 21 or more years of experience reported significantly lower burnout (0-4 years $p = .022$; 5-10 years $p=.014$; 11-20 years $p=.006$) and compassion fatigue (0-4 years $p = .002$; 5-10 years $p=.041$; 11-20 years $p=.032$) than less experienced nurses. Compassion satisfaction was significantly higher ($p=.040$) and burnout significantly lower ($p=.040$) among nurses who reported higher tolerance to violence compared to those whose tolerance was similar to their coworkers.

Implications

Despite the presence of multiple prevention strategies, there was widespread exposure to violence, yet an overwhelming majority of respondents felt safe at work and expected it as part of the job. This begs the question of whether or not expecting and having a high tolerance to violence leads to perceived safety? Lack of reporting is cited as a barrier to violence prevention. Our results reinforce that most incidents are not reported and that a lack of congruence exists between healthcare provider exposure to violence and perceptions of safety. Violence in healthcare cannot be completely eliminated; therefore, heightened awareness and the development of supportive work environments have been advocated. It is time to expand the discussion of violence in healthcare beyond awareness and prevention. Efforts can move from elimination and prevention of violence to what to do when it does happen. Investigative energy can be directed to the role of supportive work environments and strong leadership in managing violence, particularly mitigation of the effects of violence, including compassion fatigue, when it does occur.

Learning objectives

Participants will...

1. describe the relationship between perception of safety and tolerance to violence among a multidisciplinary sample of emergency department employees.
2. describe the relationship between perception of safety and exposure to violence among a multidisciplinary sample of emergency department employees.
3. describe the relationship between exposure to violence and compassion fatigue and compassion satisfaction among a multidisciplinary sample of emergency department employees.

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New Tools and a Collaborative Strategy: A Bold Approach to Reduce and Prevent Workplace Violence

Sub-theme: Aggression and/or violence toward staff or service users

Workshop

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Keywords: Workplace violence prevention, collaboration, tools, healthcare, nurses

Introduction

Keeping nurses safe on the job is vital to quality care. While workplace violence can impact all health care providers, recent statistics indicate nurses experience the highest rates of assault since the rate of violent incidents are correlated with patient contact time (Phillips, 2016). Worldwide, workplace violence (WPV) is a prevalent hazard for health care workers with both short-term (e.g., acute trauma/injury) and long-term (e.g., psychosocial) effects that are costly to the worker and organization. It is estimated that workplace violence is three times more likely to occur among health care workers than any other occupation, including police officers and prison guards (International Council of Nurses, 2001; Kingma, 2001). In Ontario, acute care, long-term care (LTC) and community care are the largest segments of the health care workforce representing over 75% of the approximately 787,000 workers. These subsectors also represent the areas where WPV incidents are most prevalent. In 2014, 30.8% of lost-time injuries (LTIs) as a result of WPV in Ontario occurred in the health care sector (WSIB EIW, 2014) and in Canada, out of 34 occupational categories, more work days were lost among nurses than any other category bar one (Dabboussy & Uppal, 2012).

Unfortunately, these cases of workplace violence across many health care settings in the world have largely been underreported, are tolerated and often ignored (Phillips, 2016). For nurses working in areas where the incidence of violence was the highest, including emergency departments, studies indicate exposure to violent events was significantly related to decreased productivity (Gates, Gillespie, & Succop, 2011). The incidence of workplace violence in a health care setting not only impacts patient safety and the quality of care, but also leads to the deterioration of staff health and the work environment, increased costs and affects nursing recruitment and retention (Bujna, Casselman, Devitt, Loverock, & Wardrope, 2015; Kingma, 2001). Though recent stories in the media and public relations campaigns across many jurisdictions have helped to push the issue into the mainstream, the “Culture of Silence” that surrounds workplace violence incidences persists (Phillips, 2016). To improve the safety of health care professionals, the Michael Garron Hospital (MGH), a Canadian leader in workplace violence (WPV) prevention, has partnered with the Ontario Nurses’ Association (ONA), the trade union representing 62,000 nurses, and the Public Services Health and Safety Association (PSHSA), an agency that advises public sector organizations on workplace safety. This partnership is a first of its kind in Ontario, Canada.

Background

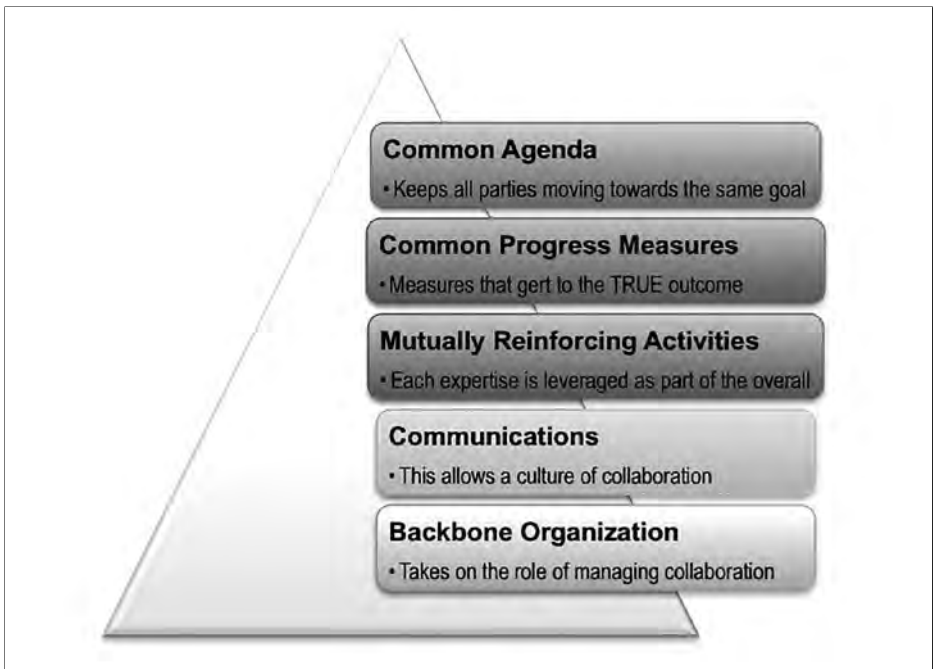
In 2006 senior leaders at MGH supported the creation of a WPV prevention program to encourage a culture of zero tolerance for all forms of violence, while addressing many factors that contribute to potentially violent situations. The program provides staff with tools, training and education to stay safe while on the job. The leadership realized that tackling a systemic issue required a collaborative approach built on strategic partnership. The commitment and involvement of the executive, a partnership with ONA, PSHSA and other unions were key drivers in the hospital-wide, cultural shift around WPV prevention. Initially, the group of stakeholders first joined together for the joint purpose of “cooperating.” They demonstrated how a group of divergent stakeholders moved from an information exchange structure to one of higher level collaboration. As the program matured, there was growth from self-interest to common interest and a movement from “cooperating” to “collaborating.” The collective has now progressed towards achieving a common goal and large system impacts of addressing WPV at a global level.

Methodology

The success of the MGH WPV prevention program is a result of strategic partnerships among the hospital, ONA and PSHSA, anchored by the *Collective Impact Framework* developed by Kania and Kramer. Nestled in east Toronto, MGH is an acute care, teaching community hospital that serves a diverse, multi-cultural community of almost half a million people. PSHSA is a non-profit agency that serves Ontario's public service sector by helping to achieve safer and healthier work environments through prevention training, risk assessment and safety consulting services, as well as a wide range of training and information products. ONA works to advance the social, economic and general welfare of roughly 60-thousand registered and graduate nurses and allied health professionals, enabling them to provide high-quality health care.

While partnership among stakeholders to solve a social problem is not a new concept, the MGH, ONA and PSHSA collaboration differs from many other initiatives. John Kania and Mark Kramer first described the notion of *Collective Impact* in 2011. It is within the Collective Impact Framework that grounds the relationships between these three organizations and helps them progress toward a shared solution. See Figure 1.

Figure 1. Source: *CollaborationforImpact.com*



First, the notion of Collective Impact is defined as a commitment among a group of important “actors” from different sectors coming together toward a common agenda and objectives (Kania & Kramer, 2011). According to Kania and Kramer, Collective Impact initiatives involve five key elements: common agenda, shared measurement, continuous communication, mutually reinforcing activities and a backbone organization that serves the entire initiative (Kania & Kramer, 2011). The Collective Impact Framework establishes the mechanism for the three organizations to guide the partnership toward a productive cross-sector collaboration rather than creating isolated interventions from each individual agency. Within this framework, despite their individual differences, there is a mutual trust and understanding of a shared mission, vision and values within the context of solving the social problem. In essence, there is a strong, collective desire for management through consensus, similar to a way some organizations collaborate during disasters and emergencies (Forsdick, 1995).

Outcomes

At MGH, the WPV prevention program resulted in several positive outcomes; increased staff satisfaction, a decrease in the frequency and severity of incidents, and a workplace cultural change around workplace violence (Bujna *et al.*, 2015). The partnership and the resulting success in injury reduction enabled the PSHSA and ONA to leverage support from the Ministry of Labour to initiate a multi-stakeholder committee to create a toolkit led by PSHSA that included tools and resources to support:

- organizational risk assessment;
- client risk assessment;
- patient flagging;
- security function review; and
- personal safety response systems.

Most importantly, the partnership has caught the attention of media and provincial decision-makers and has resulted in a larger, broader discussion of the impacts of violence in Canadian healthcare workplaces. MGH continues to lead by example. Many health care organizations have reached out to MGH and partners for guidance and coaching in the area of workplace violence prevention. In fact, members of the MGH Workplace Violence Committee, in partnership with ONA and PSHSA, have engaged and spoken to a number of stakeholder groups to raise awareness of the issue. This increase of activity and system-wide discussion of workplace violence prevention indicates that leveraging expertise, working within the Collaborative Impact Framework, developing solutions and utilizing a multi-faceted approach to issues management in healthcare that builds relationships is more effective than working in silos.

Implications for workshop participants

The presentation will provide an overview of the WPV prevention program and the impacts of the collaborative partnerships for frontline staff, the Joint Health and Safety Committee, managers and administrators, labour leaders and policy-makers including:

- Evidence and best practices that have enabled a successful collaborative model;
- A demonstration of tools and tactics that participants can use to create and/or strengthen their own WVP programs.
- Participation in learning activities that will demonstrate the use of a WVP toolkit that was developed using the following three phase approach.

Phase 1 – Discovery, included the following: (a) application of a literature review; (b) application of a jurisdictional scan, (c) focus groups and interviews to examine workplace practices, mechanisms and methodologies to manage violence, aggression, and responsive behaviours, and identify barriers to effective knowledge transfer; (d) survey of broader stakeholder group (i.e., managers and frontline staff), and; (e) develop marketing and informational materials.

Phase 2 – Design / Development, included the following: (a) determine areas of focus from priority list and establish working groups for each area of priority; (b) design and develop model and toolkit; (c) establish and implement communications plan, and; (d) develop and implement the research and evaluation plan.

Phase 3 – Delivery, included the following: (a) pilot toolkit (including, in chronological order, usability assessment focus groups, toolkit training, toolkit implementation, and formative evaluation focus groups); (b) identify secondary stakeholders for ongoing knowledge mobilization (KMb); (c) begin to connect with non-healthcare sectors to see which tools might be appropriate; (d) implement communications plan with secondary stakeholders (in-person and through technology to reach dispersed stakeholders), and; (e) develop education session and implementation plan to deliver and roll-out model and toolkit.

Acknowledgements

The authors would like to thank the many stakeholders from Employer, Labour and Professional Associations; the Ontario Ministry of Labour and Health; and frontline managers and staff who assisted the PSHSA in the development of the tool-kit that will be the subject of the workshop portion of the presentation.

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Learning objectives

Participants will...

1. gain an overview of the various processes, partnerships and structures that must be in place to develop and sustain an effective workplace violence prevention program.
2. Be able to identify key successes and challenges that will further increase the understanding of management and mitigation strategies related to workplace violence prevention.
3. Be able to discuss and reflect about the topic of workplace violence prevention in the hopes of program spread.

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Risk factors for aggressive incidents in emergency primary care – a qualitative study

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Qualitative research, aggression, workplace violence, primary care, risk factors

Introduction

Working in emergency primary care is associated with high risk of experiencing aggression and violence from patients and visitors (1, 2). In Norway, one in three has been physically abused during their career in emergency primary care (1). Norwegian municipalities are obliged by law to provide emergency primary care around the clock. Emergency primary care is organised in specific clinics or in a general practitioner's office for out-of-hours services. Many of the clinics are small, isolated and situated far from the local hospital. They are not integrated in hospital emergency departments as in many other countries. The number of staff on duty varies from one to several persons, mainly physicians (mandatory) and nurses. In many clinics there is only one person on duty. The physicians primarily see patients at the clinic, but they also conduct home visits and participate on site in emergencies outside hospitals. When nurses or other health personnel are present, they perform triage in the patients' initial contact with the clinics, give advice when appropriate and assist the physician.

Workplace violence is a complex phenomenon, and contextual factors are likely to have an impact (3, 4). To promote a better understanding of the violence, Cutcliffe has presented a systemic framework for risk factors based on findings from mental health care (5, 6). In the model four aspects contribute to aggression and violence: 1) Environmental-related phenomena (like structure and lay out of the unit), 2) intrapersonal/client-related phenomena (like cognitive and emotional state), 3) system-related phenomena (like unit policy, rules and culture), and 4) clinician-related phenomena (like communication skills and stress level). Although risk factors for workplace violence previously have been studied in primary care (2, 7-10), few studies have organised their findings beyond listing the identified factors. The context of mental health care differs from that of primary care, but Cutcliffe's four aspects may still prove to be useful in this setting. The aim of this study was therefore to identify risk factors in narratives of experienced work-place aggression and violence shared by nurses and physicians working in emergency primary care in Norway, and to systematize the risk factors according to Cutcliffe's systemic framework.

Methods

A focus group study was performed with a purposive sample of 37 nurses and physicians aged 25–69 years (Table 1). The participants had work experience from an organizational and geographical diverse subset of Norwegian emergency primary care clinics. Eight focus group interviews were conducted, and the participants were invited to share their experiences of violence in emergency primary care with focus on how they had dealt with the violence. The main question was: Can you tell about one episode of experiencing threats or violence at work in emergency primary care? In the analysis, we used systematic text condensation (11), which is a descriptive approach focusing on the experiences expressed by the participants themselves, rather than exploring possible underlying meanings. During the first analysis on how participants dealt with violence, which is published elsewhere (12), we found several descriptions on perceived risk factors. In the present study we therefore changed the focus, and searched the narratives systematically for described risk factors. A risk factor is in this study defined as a factor influencing an incident of aggression and violence, including both determining and regulating factors (13). The findings were organized according to Cutcliffe's systemic model of risk factors (5) (6).

Results

We identified risk factors in all four aspects described by Cutcliffe. The results will be presented at the conference.

Discussion

Strength and limitations

The strength of our study is that the stories are told by nurses and physicians from different parts of Norway and a diverse subset of clinics, and therefore describe varied situations and risk factors in emergency primary care. A limitation to our study is that the focus group study included health personnel only, and that the description of risk factors are based on their perception and interpretation of the event.

Acknowledgement

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Table 1. Demographic background of participants in the eight focus groups (n=37)

		n	%
Profession	Nurse	15	(41)
	Physician	22	(59)
Gender	Female	23	(62)
	Male	14	(38)
Age	<30 years	3	(8)
	30-39 years	18	(49)
	40-49 years	8	(22)
	≤ 50 years	8	(21)
Years in emergency primary health care	≤ 5 years	18	(49)
	<5 years	19	(51)

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Learning objectives

Participants will...

1. have an understanding of risk factors for aggression and violence in emergency primary care.
2. appreciate the value of a systemic framework to help choose appropriate interventions.

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The counter-aggressive response to Patient Aggression

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Patient aggression, nurses, workplace aggression, structural equation model

Abstract

Work-related violence is a serious safety and health hazard. Moreover, employees in certain sectors are at greater risk than others. In particular, according to the European Agency for Safety and Health at Work Report (EU-OSHA, 2010), the highest incidence of workplace violence is found in the health and social work sectors. According to the international literature findings consistently indicate that patient and visitor aggressions against healthcare staff are the most prevalent work-related violence in the healthcare system (Camerino *et al.*, 2008; Eurofound, 2013; Roche *et al.*, 2010) with approximately 22-90% of healthcare workers suffer verbal abuse, 12-64% physical threats, and 2-32% physical violence (Pompeii *et al.*, 2013). Less is known about the impact of patients' aggression on outcomes other than workers' health and well-being, especially when considering that these are not the only consequences. Indeed, extensive literature underlines that stressful events at work may lead to workers' aggressive response (Spector & Fox, 2005). Employees misbehaviour in the health care context can have serious consequences on the quality of the care and even on patients' health.

The primary aim of the study is to examine whether aggression from patients and their relatives may result in nurses workplace aggression towards colleagues and in relation to clinical practice.

Results of a structural equation model on a sample of 374 nurses (about 55% females, mean job tenure 13 years SD=10) confirmed that third party aggression (physical and verbal aggression and threats thereof) is associated with workplace aggression acted by nurses.

Aggression experienced at work is a dramatic phenomenon with potential consequences not only on the direct victim but also on the entire organisational system, where it is possible to envisage the primer of vicious circles leading to a broader and escalating diffusion of different forms of workplace aggression.

In order to manage this phenomenon, it is essential to consider that victims can have not only health related consequences but also externalising ones, which are usually an undermined outcome in intervention programmes. When designing these interventions, a multi-focal perspective should be adopted by considering the worker as both a victim exposed to health problems and as a potential perpetrator bearing his/her frustration, hostility, and anger. Clearly, we are not stating that all victims of aggression become perpetrators, but some of them can be more at risk to counter-aggressive outcomes.

Learning objectives

Participants will...

1. appreciate the value of structural equation modelling to detect new dimensions of aggression and violence.
2. gain an understanding of a potential additional consequences of aggression experienced at work from patients and relatives.

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Perceptions of healthcare students related to violence against healthcare staff in Turkey

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Perception of violence, health care students, violence in health sector

Introduction

Violence against healthcare staff is an alarming problem in both developed and developing countries.^{1,2} According to report The Bureau of Labor Statistics in 2011, more than half of US healthcare workers (over 2 million) have been exposed to violence in a year.³ In a study in 2015, it is reported that the percentage of health care workers who experienced workplace violence in Turkey in the last 12 months is 44.7%.¹ Also in a systematic review conducted in Turkey, authors revealed that 46.7-100% of staff were exposed to verbal, 1.8-52.5% to physical, 1.1-73% to sexual, and 33.3-86.5% to emotional violence.⁴

Violence against healthcare staff is a concern because violence at this level in our health sector could affect the quality of patients care and image of the professions.⁵⁻⁸ Evidence suggests that health care staff frequently experience violence and aggression resulting in potential impairment of physical and mental well-being in the affected person.^{2,3} Furthermore, studies suggest that the consequences for the patients and the entire organization are severe. Violence and aggression can, for example, negatively affect the quality of care and treatment, cause longer periods of absenteeism, deteriorate the work climate² and lack of commitment to facility.⁹

Studies on violence in health were conducted mostly through health staff. To our knowledge, in Turkey, no other study covered this population yet. Therefore, the present study examines perceptions of healthcare students related to violence against healthcare staff to educate them in the future. In this context, the aim is to evaluate the perceptions of students related to violence against healthcare staff.

Methods

This cross-sectional descriptive study was performed between January - April 2014. The study population consisted of all students (1764) in the Health Science Faculty of a university in Turkey. During the study period, the Health Science Faculty consisted of nursing (722 students), midwifery (274 students), physiotherapy and rehabilitation (280 students), nutrition and dietetics (168 students), health management departments (320 students). The sample included 1143 students from first to fourth year who accepted to participate the study (participation rate 64.8 %). Approval for the study was granted by the ethics committee and dean of the faculty. Informed consent was obtained from all the students.

Data were collected through a questionnaire form developed by the researchers as based on the literature. The questionnaire form included six demographic question and the others included response items: a. aggression towards healthcare staff in their personal lives (5-item), b. their opinions against health workers in Turkey (4-item), c. their recommendations for the prevention of violence (1-item).

Violence was defined as any form of verbal, physical and sexual aggression and/or physical violence.²

The questionnaire form was administered in an interview format by the researchers between January and April 2014. Data is presented as mean (\pm) standart deviation and frequency distribution. Chi-square test was used in the statistical analysis. $p < 0.05$ was adopted as statistical significance value.

Results

There were 1143 voluntary participants; 74.9% (856) of the sample were females and 25.1% (287) males. 42.2% (487) of the nursing, 16% (183) of the midwifery, 14.8% (169) of the physiotherapy and rehabilitation, 11% (126) of the nutrition and dietetics, and 16% (183) of the health management departments participated. The mean age was 20.23 ± 1.84 (range: 17-35). A total of 366 participants have verbally assaulted healthcare workers in their personal life at least one time. The majority of the students who verbally assaulted healthcare workers were males: 38% versus 30%, respectively ($p < 0.05$). The incidence of assault towards the healthcare staff in the personal lives of the students are shown in Table 1.

Table 1. The distribution of assault towards healthcare staff in the personal lives of the participants (N=1143)

Variables	No (%)	
Assault	No	777 (68)
	Once	266 (23.3)
	Twice to five times	89(7.8)
	> Five times	11 (1)
Type	Verbal	366 (100)
Causes*	Indifference	221 (60.3)
	Loud reaction	131 (35.7)
	Insufficient information	115 (31.4)
	No empty bed	53 (14.4)
	No improvement of the disease	40 (10.9)
	Long-term treatment	36 (9.8)
Clinics*	Emergency service	152 (24.5)
	Surgical departments	150 (24.1)
	Internal medicine	109 (17.5)
	Obstetrics	62 (10)
	Orthopedics	45 (7.2)
	Child clinic	44 (7)
	Psychiatric service	31 (5)
	Intensive care unit	27 4.3
For whom	Patient	204 (55.7)
	Own	162 (44.3)

* Multiple responses were given to this question, percentage values were calculated based on the number of respondents.

According to the participants, violence has been increased in our society and in health in recent years (respectively 93.4%, 93.2%). The contributing factors to violence consisted of the patients' low socioeconomic level (67.2%), the lack of support from hospital managers as well as proper legislations to defend staff (61.2%), the negative public image of healthcare staff (50.5%), overcrowding of healthcare facilities (43.6%), waiting for being visited by physicians (39.4%), workload of the staff (%33.4%), inefficient staff (28.8%), and insufficient information (28.8%).

When asked about their opinions related to healthcare workers who are exposed to violence (beating/killing), 54.5% reported that they think none of the health workers deserved it and 25% stated that they are worried about the future of their profession. Nursing and midwifery students were more worried about the future of profession than students of physiotherapy and rehabilitation, nutrition and dietetics, and health management: 30.1%, 27.3% versus 19.5%, 23.8%, 15.3%, respectively ($p < 0.001$). The perceptions of healthcare students related to violence against healthcare staff in Turkey are given in Table 2.

Table 2. Perceptions of healthcare students related to violence against healthcare staff (N=1143)

Variables	No (%)	
Violence against healthcare workers	Gross injustice	940 (82.2)
	Necessary only in some cases	203 (17.8)
Deserve	No	1084 (94.8)
	Yes	59 (5.2)
Be prevented	Yes	917 (80.2)
	No	226 (19.8)
Thoughts about personnel exposed to violence (beating / killing)	No health worker deserved it	623 (54.5)
	Worry about the future of the profession	286 (25.0)
	It was a pity	192 (16.8)
	It is deserved.	42 (3.7)
Recommendations to prevent violence*	Appropriate legal arrangements	703 (61.5)
	Safety precautions	679 (59.4)
	Training of staff	567 (49.6)
	Training of public	415 (36.3)

* Multiple responses were given to this question, percentage values were calculated based on the number of respondents.

Discussion

Verbal aggression is the dominant form of violence reported. In Turkey, it is reported that more than half of healthcare workers were exposed to verbal aggression and approximately one in seven to physical violence.⁴ This situation is similar to many international literature.¹⁰ In this study, a significant proportion of the participants (32%) stated that they verbally assaulted healthcare staff at least once throughout personal life. Most of the assailants were males, similar to literature.^{4,11-17} This may be a result of being a male dominated society.

Verbal aggression was most frequent in emergency service (24.5%). Similar to our findings, most previous studies showed that violence against the emergency staff is common.^{11,12,18} In various studies in Turkey, this ratio ranges from 57.3% to 60%.¹⁹ In a study by Guglielmetti et al¹⁸ showed that the risk for emergency department health professionals is higher than professionals in the other areas. However, violence is also common in the medical and surgical clinics.²⁰

Many international studies have shown that perpetrators were the patients.^{14,15,21-23} For instance, James *et al.*¹² reported that 88.2% of offenders were patients and 11.8% were relatives or visitors, but this study showed 55.7% of assailants to be relatives, similar to the national literature.⁴ This difference is, most likely, caused by cultural differences. Because in our culture, patient's relatives are constantly at the hospital with the patient and they have been made a part of the treatment and/or the care by the system and care providers.

Less than 20% of the participants reported that they think violence against healthcare workers is necessary only in some cases. 5.2% stated that healthcare workers is deserved the violence. The most important reason was indifference of staff. In a study by Ilhan *et al.*¹⁹ these ratios were found 22.9% and 20.2% respectively. Our findings were lower than theirs, however this is still a worrying situation. It is a major problem that people having too much expectation from the health workers, turning to violence when their expectations are not met, and express it as their rights. This situation may be a result of misinformation in media as well as lack of staff and their fatigue.²⁴ Similar to our findings, Ilhan *et al.*¹⁹ found that interns and assistant doctors were exposed to violence more when they did not perform the expected behavior (32.3%, 34.4% respectively). In other studies conducted in Turkey have been reported reasons such as the long waiting time,^{4,24-29} extreme demands of patients and their relatives, low levels of education, and failure to comply with rules.^{19,24,25,28,30} Hahn *et al.*²³ and Carmi-Iluz *et al.*³¹ also point out the organizational problems (long waiting time, patients' and their relatives' excessive demands, service rules, and payment difficulties) as the most common cause of violence.

Our study revealed that one of the four students are worried about the future of their profession. This may be due to increased news related to violence against healthcare staff in media, lack of sanctions for the perpetrators, and increasingly common trend of violence in society in recent years. This study demonstrated that nursing and midwifery students were more worried about the future of profession than others. This situation may be due to the majority of the students being female and increased violence news towards female and nurses in media. Especially violence against nurses is highly prevalent in Turkey. Verbal aggression is more common among females than males. Both verbal and physical aggression are more common among female staff and among nurses as profession.⁴ Most studies show that violence against the female and nurses is more common.^{3,19,25,32,33}

More than half of respondents thought improving legal arrangements and safety precautions as an effective way to the prevent violence. This condition may be due to lack of sanctions or seem to be insufficient in the punishment for the perpetrators.

In conclusion, this study showed that a remarkable part of healthcare students, who will be care provider in the future, think that violence against healthcare workers is necessary only in some cases. On the other hand, our study showed that one-third of students were worried about their professional future. Given individual, institutional and social negative effects of violence, educational programmes and appropriate training are needed to heighten awareness of this problem among healthcare students.

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Learning objectives

Participants will...

1. learn about perceptions of healthcare students related to violence against healthcare staff.
2. be able to discuss the effects of violence in health sector on students.

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Aggression in German Acute Care Hospitals – Results of a Mixed Methods Study

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Introduction

Aggression by patients and visitors in the health care sector is a well-known international problem (Jackson, Clare, & Mannix, 2002). Compared to professionals in other occupational groups, health care professionals have a high risk of experiencing aggression by patients or visitors (Camerino *et al.*, 2008; Estry-Behar *et al.*, 2008). Most studies on patient and visitor aggression have been conducted in either mental health or emergency care settings (Estry-Behar *et al.*, 2008). However, health care professionals in general hospitals also encounter aggression by patients and visitors. At least 85% of Swiss health care professionals working in a general hospital have experienced aggression by patients or visitors at least once during their career (Hahn *et al.*, 2012). Patient, staff, environmental and organisational factors such as age, lack of information, job experience, noise, low staffing ratio or prohibitions enforced on patients and relatives (e.g. enforcing a ban on mobile phone usage) can promote the occurrence of aggressive behaviour toward health care professionals (Hahn, 2012; Hahn *et al.*, 2013). Such aggressive incidents can harm the institution (staff absence, property damage and job dissatisfaction) as well as the employees (Camerino *et al.*, 2008; Winstanley, 2005; Jackson *et al.*, 2002). Health care professionals affected by aggressive behaviour can sustain physical and mental health problems (e.g. insomnia, anxiety or posttraumatic stress disorders) (Gerberich *et al.*, 2004; Richter & Berger, 2009). Although numerous consequences caused by aggressive behaviour of patients and visitors are well-known, institutions in health care seem to provide insufficient support for their employees. Therefore, the aim of this study is to assess the current situation in German general hospitals in regards to patient and visitor aggression.

Method

A mixed method was used, whereby the quantitative data was collected first and secondly the qualitative data. All data was analysed separately and merged in a way that the qualitative data could be used to help interpret the quantitative results. The data collection took place between February and October 2015. The quantitative part was conducted as a cross-sectional survey. All health care professionals working in two German hospitals were invited to participate either by filling out a printed survey (including a reply envelope) or an online version of the survey provided by SurveyMonkey. All data were descriptively analysed using SPSS 23. The qualitative part encompassed three semi-structured focus group interviews. The interviews were recorded digitally and transcribed. For the analysis, a deductive content analysis according to Mayring (2015) was used.

Findings

567 health care professionals participated in the survey, whereas 12 nurses and 6 physicians participated in the focus group interviews.

Frequency of Aggression

About 62% of the health care professionals experienced verbal or physical aggression from patients/visitors during the past 12 months; 41% of those experienced the same in the last seven days. Concerning the frequency, verbal aggression (94%) occurs more often than physical aggression (32%). Furthermore, health professionals report that the occurrence of “aggressive behaviour” has become more frequent in recent years and that it was less common two or three years ago (FK2, TN1). Incidents with physical aggression are reported in the interviews but the participants remarked that “usually it is verbal aggression” (FG2, P2) that they have experienced.

Causes and time of Aggression

The main organisational reasons for experienced physical and verbal aggression were long waiting times (33%) or staff not having enough time for the patients (29%). In most of the reported incidents of verbal or physical aggression, the patients suffered from a primary diagnosis of mental/behaviour disorders (25%), a secondary diagnosis of dementia (48%), delirium (24%) or intoxication (15%). Most of the health professionals identified the source of the experienced aggression as incomprehension of the situation (16%), excessive demands (13%), fear (10%) or dissatisfaction with the therapy (9%) by patients or their relatives. The majority of cases of aggressive behaviour towards health professionals occurred while the health professionals were providing care that required close physical contact to patients (21%). In the interviews, participants mentioned that the frequency of experiencing aggressive incidents is higher in late shift work. They experienced “far more aggression in the afternoon shift than in the morning or during the night shift” (FG2, P6). The professionals ascribe these phenomena to the staff ratio and the resulting lack of time.

Burden of Aggression in daily routine

For almost two-thirds of the respondents, the burden of experiencing verbal aggression was moderate (45%) to strong/very strong (26%). Regarding the burden experienced after having experienced physical aggression, 34% of the health professionals reported having felt a moderate and 24% a strong/very strong burden. Of health care professionals who had experienced aggressive incidents by patients or visitors, 6% were absent from work due to sickness following such incidents, in most of the cases for 2-3 working days. Findings from the interview show that the experienced burden is higher if the aggressive behaviour experienced is by the relatives, because they are healthy and their aggressive behaviour is not by reason of a disease.

Direct and indirect aggression

Numerous health professionals remarked that, in the experience of aggressive behaviour, it made a difference whether the aggressors were cognitively competent or impaired. If the experienced aggressive behaviour could be explained by illness or disease, the health professionals felt less stressed. Health care professionals try to differentiate. “By patients with cognitive impairments [...] you can explain their behaviour because of that. What I personally find worse is aggression from patients without any cognitive impairment. It distresses me more” (FG2, P1).

Coping with experienced aggression

In coping with aggression, most health professionals appreciate the contact and dialogue with team members, (37%) appreciate the contact and dialogue with their partners and (22%) with other relatives/friends (13%) or their supervisors (10%). While nurses prefer to talk with colleagues, physicians remarked in the interview that they rarely talked about experienced aggressive behaviour among colleagues. As the results of the interviews showed, many of the health professionals take the burden into their private life; “you take it home with you and you can’t stop thinking about it [...]. You suffer from it at home a little” (FG2, P3).

Conducted Interventions

To deescalate aggressive incidents, most of the health professionals conducted a calming (23%) or an informing conversation (20%), while 18% of the health professionals requested from aggressive patients/visitors that they change their behaviour (18%).

Training opportunities

Most staff (76%) had not received any training in aggression management. 62% of the health care professionals felt unconfident in dealing with verbal aggression and 84% in dealing with physical aggression from patients/visitors. However, for 69% of the health care professionals, a training in dealing with aggressive patients/visitors in the workplace is important. Furthermore, the staff mentions the inadequate contents of the trainings. “They [the trainings] were nice, the police conducted them but for me it was no use [...]. I can’t just walk away, as they wanted us to do when someone seems aggressive” (FG2, P1).

Organizational Support

Around 25% of the health care professionals state that not enough support is provided and 37% that it is difficult to get enough support from their organisation. However, 96% mentioned that support for an affected staff member is necessary. Concerning this matter, 59% of the managers indicated that there is not adequate support for their staff. In addition, 69% of the health professionals do not know if the organisation has an official position in dealing with patients and visitor aggression towards staff and 24% of health professionals state that there is no official position. Two participants stated: “The hospital should be interested in our feelings and listen to us” (FG2, P1) or “I wish the persons with a higher position would tell the clients to not behave aggressively, but they are focused on client satisfaction” (FG2, P2).

Perception of managers

Most managers (55%) indicate that no financial resources were invested for prevention and intervention strategies regarding patient and visitor aggression in clinical practice. Furthermore, for 82% of the managers, aggression towards health care professionals is an important issue in their organisation and for 77% in their own area of responsibility. Most managers (68%) state not to have an adequate reporting system to assess aggressive incidents and reports of aggression often do not reach the necessary hierarchical level (54%).

Possibilities for Support and improvements

Most participants of the focus groups indicate the need for an adequate staffing level, a reinforcement of security, adequate support following an incident of aggression and an official positioning of the organisation to protect staff members from patient and visitor aggression, as one stated: “We already had a guard, who was retired. He wouldn’t have been able to intervene in an escalation. Now we have a younger one. We can call him from 8pm” (FG1, P6). For the professionals, the training alone is not enough. They emphasise the importance of increasing the staff ratio. “We need manpower. There are four men on a huge ward and only one [female] doctor is present. Three or four more of us [other health care professionals] is the only solution” (FG3, P4).

Discussion

In comparison with a similar inquiry by Hahn *et al.* (2012) in a Swiss university hospital about the frequency of experienced aggressive behaviour (50.5%), health care professionals from the two German hospitals experienced more aggression from patients and visitors in the last year (62%). However, the results are quite comparable with other study results. Furthermore, the employees who had experienced verbal abuse were more affected by aggression directly targeted at themselves by people who are cognitively adequate (Peter & Hahn, 2015; Richter, 2012).

Likewise, in the study by Peter and Hahn (2015), the health care professionals remarked claimed to have insufficient time for the patients and the visitors. Suboptimal organisational structures, time pressure as well as a low staff ratio are experienced triggers for aggression. Shields and Wilkins (2009) and Camerino *et al.* (2008) refer to inadequate staffing as a promotor of aggressive behaviour, which can reduce the staff satisfaction to a perceptible degree (Estry-Behar *et al.*, 2008; Winstanley, 2005). For the health care professionals, the institutions’ attitude towards the handling of aggression at the workplace seems to be important. The results of Hahn (2012) showed that health care professionals had a lower risk of experiencing aggression when their institution took a position against aggressive behaviour. In this connection, good organisational culture and climate are crucial (Registered Nurses’ Association of Ontario, 2009).

Conclusion

- **Minimize risk factors:** An analysis of specific risk factors to the setting is important to identify institutional risk factors. Consequentially, specific preventive interventions for the workplace can be derived. The SAVEinH model by Hahn (2012) can provide an informative basis for potential risk factors.
- **Professional training:** Health care professionals require disease- and workplace-specific antiaggression trainings. These trainings are needed to call health care professionals’ attention to potential risk factors of aggressive behaviour and available institutional support as well as for the training of adequate communication strategies and suitable interventions.
- **Safety precaution and the institutions’ positioning:** Health care professions need the support of their institution (Stokowski, 2011) and the implementation of a corporate safety policy. A clear, official statement of the institution against aggression from patients and visitors is crucial. It is recommendable to establish an adequate and efficient security system. Additionally, staff ratio has to be improved to an adequate level.
- **Institutional follow-up support after an experienced aggression:** A discussion in the team, mental support given by team members or support from the personal environment is insufficient for an effective follow-up. An institutional follow-up with support from trained counsellors or from the psychological services is needed.

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Learning objectives

Participants will...

1. have a basic understanding of the contexts and specific situations in which aggressive acts in acute care settings occur.
2. become acquainted with measures that may help to advance aggression prevention and staff support in the participating hospitals.

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The perception of people admitting to health centers about violence against healthcare staff

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Occupational health, violence in health, perception of violence in health

Violence is an important social problem in developing and industrializing countries¹. Workplace violence is defined as “employees being subject to abuse or violence in work related situations”²; whereas violence in health facilities involve “situations that pose a risk for health personnel such as threat behavior, verbal threats, economical abuse, physical violence and sexual assault perpetrated by a patient, patient relative or other people”³. The reasons for such violence include lengthy waiting periods at clinics⁴, low levels of education⁵, noncompliance with hospital rules⁶, financial shortcomings¹, insufficient security measures and police back up at health facilities⁷, and patients’ excessive demands and the over crowdedness of health facilities⁸.

In a joint 2002 report which was titled “Workplace Violence in the Health Sector” and issued by the World Health Organization (WHO), International Labor Office (ILO) and International Council of Nurses (ICN), more than half of health personnel stated that they were exposed to violence at some point during their professional life⁹.

In the international literature, studies that focus on violence against health personnel showed that 36.4% of personnel in Japan^{10,11}, 27.7% in Egypt¹², and 13% in the USA¹³ were subject to violence. Violence against health personnel was most common in emergency services; while female personnel and nurses were more likely to be exposed to violence^{13,14,15}.

According to the report of the Assembly Research Commission, which was founded by the Grand National Assembly of Turkey (GNAT) in 2013 in order to determine the precautions necessary to prevent the rising rates of violence against health personnel, violence is more common in the health sector and that the health sector is 16 times more risky than other sectors in terms of violence^{16,17}.

In Turkey, studies on violence in the health sector were mostly conducted with health personnel. However, studies that measure the perception of violence in people admitted to health facilities are limited^{2,4}. In this context, the objective of the current study was to evaluate the perception of violence against health personnel in people admitted to health facilities.

Method

This study was carried out in January, 2016 in the clinics of a Turkish public hospital. A total of 656 people who were older than 18 years of age were included in the sample.

Data was collected using a questionnaire titled “Evaluation of perception of violence against health personnel in people admitted to health facilities”, which was developed by the researchers.

Data was analyzed using descriptive statistical methods (number, percentage, mean, standard deviation) and significance tests for categorical variables. Level of statistical significance was accepted as $p < 0.05$.

Results

Mean age of the participants was 33 ± 12.7 (range: 18-73); while the majority of the participants were female (64%), single (51.5%), high school graduates (48.8%), unemployed (32.9%), and had an equal income-expense rate (60.4%).

The majority of participants reported that health personnel was mostly exposed to verbal violence (87.2%) and that violence occurred mostly in public hospitals (81.1%) and in emergency services (65.2%). The first three reasons of violence reported by the participants were “being indifferent to patients/their relatives (70.7%)”, “not being addressed (61.9%)”, and “communication problems such as misunderstanding (56.7%)”, respectively (Table 1).

Table 1. Distribution of Responses to Questions on Violence Against Health Personnel

Variables	n	%
Most frequent type of exposure to violence among health personnel		
Physical	82	12.5
Verbal	572	87.2
Sexual	2	0.3
Facilities where violence was thought to most frequently occur		
Family health center	4	6
Public health center	2	0.3
Public hospitals	532	81.1
112 emergency health services	68	10.4
University hospitals	24	5.2
Private health facilities	8	1.2
Private practice	8	1.2
Departments where health personnel are most frequently exposed to violence		
First step health facilities	20	3
Inpatient services	16	2.4
Intensive care services	22	3.4
Surgery rooms	16	2.4
Clinics	118	18
Emergency services	428	65.2
112 personnel	56	8.6
Reasons of violence against health personnel*		
When negative/bad news are given	117	35.7
When patients/relatives encounter indifferent behavior	232	70.7
When insufficient information about the patient is provided	165	5.1
When there are no vacant beds for the patient	70	21.3
When the patient does not receive the prescription he/she desires	38	11.6
Communication problems such as misunderstanding	186	56.7
When they are dissatisfied with the treatment	112	34.1
When treatment is lengthy	45	13.7
When they wait too long for an examination	144	43.9
When patients/relatives think they are not addressed	203	61.9
Due to insufficient levels of comfort within the hospital	21	6.4
Due to the over crowdedness of hospitals	88	26.8
Because of health personnel shouting and yelling at patients/relatives	161	49.1

*Multiple responses were given to this questions, percentage values were calculated based on the number of respondents.

As shown in Table 2, 97.3% of the participants thought that violence increased in the society in recent years, whereas 92.1% thought that violence increased in health settings. The majority of the participants (81.4%) reported that they do not consider using violence as a method for seeking one's rights. In addition, 84.1% thought that violence against health personnel can be prevented. Almost all of the participants (90.2%) answered the question about "the necessity of beating up/killing health personnel" by selecting the "totally disagree" option. Most of the participants (60.7%) thought that "none of the health personnel deserved violence", while 6.4% thought that "they deserve such" and listed their reasons as follows: "poor communication (39.3%)", "indifference (30.5%)", "speaking loudly (24.7%)", and "not providing sufficient information (22%)". Among the participants, 93% did not think that "use of violence against health personnel will solve problems". In order to prevent violence in health settings, the participants recommended that health personnel (52.4%) and the general population (79.6%) should be educated and that legal (69.4%) and institutional (51.2%) precautions should be taken for protecting health personnel from violence.

Table 2. Distribution of Participant Opinions on Violence Against Health Personnel

Variables	n	%
Status of increase in public violence in recent years		
Yes	638	97.3
No	18	2.7
Status of increase in health related violence in recent years		
Yes	604	92.1
No	52	7.9
Status of thinking of violence as a method for seeking one's rights		
Totally agree	20	3
Partially agree	102	15.5
Totally disagree	534	81.4
Thinking that violence against health personnel can be prevented		
Yes, it can be prevented	552	84.1
No, it cannot be prevented	104	15.9
Thinking that health personnel should be beaten up/killed		
Totally disagree	592	90.2
Partially agree	38	5.8
Totally agree	26	4
First reaction when health personnel are exposed to violence		
What a shame	140	21.3
No health personnel deserve this	398	60.7
I worry about my future	76	11.6
They probably deserved it	42	6.4
Reasons for thinking that health personnel deserve violence*		
Being kept waiting for an examination	50	7.6
Personnel being rude	258	39.3
Personnel answering questions in an excessively vocal manner	162	24.7
Not providing sufficient information about one's disease	144	22
Not being attentive to our patient	200	30.5
Health personnel having heavy workloads	56	8.5
Thinking that using violence against health personnel will solve problems		
Does not think so	610	93
Thinks so	46	7
Measures to take for preventing violence against health personnel *		
Education for health personnel	172	52.4
Education for the general population	261	79.6
Reducing the risk of being exposed to physical and psychological violence	138	42.1
Reducing the risk of being harmed for health personnel	123	37.5
Taking protective measures	173	52.7
Making legal regulations	213	64.9
Taking security measures (Institutional)	168	51.2
Preparing public service ads (such as TV/Newspaper/Informatics)	184	56.1

*Multiple responses were given to this questions, percentage values were calculated based on the number of respondents.

The participants thought that women were significantly more exposed to verbal violence (90.5% compared to 81.4%) and that men were more likely to be exposed to physical violence (17.8% compared to 9.5%) ($\chi^2=6.637$, $p=0.036$). As for the reasons for violence against health personnel, the participants thought that women were more likely to give bad news to patients (%40 compared to %28), to not to write the desired prescription (15% compared to 5.1%), to have communication problems such as misunderstandings (46.7% compared to 33.1%), to face dissatisfaction with treatment (41% compared to 22%), and to be indifferent (66.2% compared to 54.2%) ($\chi^2=4.768$, $p=0.029$; $\chi^2=7.603$, $p=0.006$; $\chi^2=5.758$, $p=0.016$; $\chi^2=12.025$, $p=0.001$; $\chi^2=4.557$, $p=0.032$; respectively).

Discussion

The negative impact of recently increased violence in the health sector is more clearly indicated. Similar to studies that focused on health against health personnel in Turkey^{1,2,4,18,19,20,21}, the current study demonstrated the participants thought that health personnel was mostly exposed to verbal violence and that violence was most frequently used in emergency services and clinics. These findings are in line with the international literature^{9,11,15,16}. The reasons for high rates of verbal violence may be that it enables people to let off steam and relax, that it has less severe legal sanctions than physical violence, that emergency services are stressful settings, and that patient relatives think that their patients should be of top priority.

In the current study, it was found that 6.4% of the participants thought health personnel "deserved violence". Ozturk and Babacan indicated that participants thought medical secretaries (23%), nurses (23%), and doctors (15%) deserved violence. It is a worrying situation that patients/relatives have excessive expectations from health personnel and that they see violence as a right when their expectations are not met. This may be due to the over crowdedness of hospital settings, the qualitative and quantitative incompetency of health personnel, and patients/relatives thinking that they do not receive sufficient attention since admissions to clinics/emergency services/services exceed capacity.

In the present study, the most important reasons for thinking that health personnel deserve violence included health personnel being rude to patients/relatives, not being attentive, not providing information, and lengthy waiting periods. Similar to the current study, Ozturk and Babacan also found that 41% of patients/relatives thought that personnel deserved violence due to lengthy waiting periods, 53% due to personnel being inattentive, and 21% due to not being informed about their disease. These findings can be explained by the facts that the physical properties of hospital waiting lounges are inappropriate, the patient loads are excessive, and the number of health personnel, beds, medications, and devices are insufficient.

The majority of participants suggested that the general population should be educated and then the necessary legal regulations should be made in order to prevent violence against health personnel. In İlhan *et al.*'s study, similar suggestions were reported by study participants². This situation can be explained by the frequent appearance of instances regarding violence in health settings in the media, lack of security measures in the health sector, and the shortcomings in laws which lead to inadequate punishments inflicted on perpetrators.

Conclusion

According to the current study, participants think that violence in health settings mostly occur in emergency services and public hospitals and due to the negative attitudes of health personnel. In addition, the majority of participants thought that using violence cannot be a method for seeking one's rights even though violence rates increased in the health sector and in the general population and that violence against health personnel can be prevented by educating the general population and by making legal regulations.

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Learning objectives

Participants will...

1. appreciate that the that perception of the people admitting to health center related to violence against healthcare staff in Turkey.
2. learn about the effects of violence in health sector on people admitting to health center.

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The Customer is NEVER Right: A Nurse Practitioner's Perspective

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Background and context

Healthcare, an industry genuinely dedicated to helping others and a time-honored profession, has been forced into an industry of customer-driven service, by any means necessary and at the cost of so much. As a result, satisfaction scores are the driving force and healthcare and healthcare workers must follow. Yet, that destructive IDIOT-ODOLOGY [sic] has improved neither the quality nor cost of healthcare, its original intent. Instead, it has bled healthcare and left it with nothing to show but a trail of overwhelming collateral damage and our nation's most pressing though largely silent national crisis despite all the money, time, and effort invested.

Collateral damage that includes healthcare-directed violence, a violence that has become more frequent, more brazen, and more violent despite being studied extensively by professional and government organizations. Sadly, those organizations too have nothing to show for their efforts either, other than "feel good" conflict resolution and aggression management policies that are IMPOTENT as they purposely fall short as to not offend patients or families. And despite those organizations' claims and policies, reports from victims continue to be greatly underreported as healthcare workers fear losing their jobs due to a lack of support from healthcare's submissive, altruistic, and accommodating culture, which is consumed by the devotion to customer satisfaction scores.

"Health care workplace violence is an underreported, ubiquitous, and persistent problem that has been tolerated and largely ignored," wrote J. P. Phillips, M.D. in an article titled, "Workplace violence against health care workers in the United States [of America]" published in *The New England Journal of Medicine* (April 2016).

On that note, the contents and title of this exposé are purposefully provocative as both emphasize that considering patients as customers is NEVER right. The content also points out that customer satisfaction scores are NEVER about healthcare but instead about customer retention and profits—the elephant in healthcare's exam room. On top of that, the current path healthcare is being "taken down," with regard to the customer experience, has NEVER been good for healthcare and could incite healthcare-directed violence.

Despite the studies that have shown there is no correlation between satisfaction scores and good healthcare, or worse, those who are the most admitted are the most satisfied and most likely to die, isn't it absurd that satisfaction scores are the driving force in healthcare? Again, a driving force without accomplishment as there isn't anything in healthcare that can be attributed to satisfaction scores but poor outcomes.

Healthcare administrators and pundits are well aware of all these facts; yet choose to look away from them, despite the collateral damage that results when these individuals follow policies that chase satisfaction scores. And because they choose not to speak about it, healthcare administrators DO NOT want this point of view shared, regardless of the fact it is a story and message that resonates with so many healthcare workers. In other words, it is a conversation that can make a useful contribution to the current healthcare debate going on at many levels.

This tolerated and largely ignored silent crisis is not political, although some disagree. Instead we only have healthcare's submissive, altruistic, and accommodating culture, and its obsession with customer satisfaction scores, to blame. Healthcare has not only followed the herd but it turned over the reins to outsiders who have taken healthcare down the wrong tracks with their IDIOT-ODOLOGY [sic] that they claim is in the patient's best interest.

The overwhelming numbers of patient experiences are unquestionably rewarding for both healthcare workers and patients. However, because of their sheer volume, those positive experiences blur into a single indistinguishable continuum and, unless they are remarkably extraordinary, their details are consigned to oblivion. On the flip side, the melodramas of the complaining minority are permanently etched in our memories and some physically scarred. It is those unpleasant experiences that drag us down and are the cause of misery and frustration for so many healthcare workers. As each one of those negative experiences are identifiable along the unforgiving minefield we must navigate, many times alone, to stay safe and/or keep our jobs. It is that misery and frustration which is the cause as to why so many leave healthcare and not the proposed “compassion fatigue”, as no one fatigues from helping others.

How did we get here? Since the 1980s, a belief has existed that by increasing customer satisfaction, healthcare’s quality and cost would improve. Instead we got more expensive and inferior quality healthcare through the poor decision of accommodating EXAGGERATED UNREALISTIC EMOTIONAL EXPECTATIONS, including those who tread on us, to keep our jobs.

Why? Because rather than focus on those variables that affect the quality and cost of healthcare, such as outcomes and the safety of healthcare workers and patients, satisfaction surveys focus on wait times, pain management, housekeeping, and communication skills, all of which it could be argued DO NOT affect the quality or cost of healthcare.

On top of that, healthcare pundits want us to accept the venomous behavior from those who tread on us as a rare occurrence that are the regrettable side effects of those unfortunate individuals who are demented, psychotic, or under the influence of alcohol and/or drugs. Yet, the anecdotal experience of many in healthcare has been that healthcare-directed violence is more common than not. And more common than not, it is NOT at the hands of the demented, psychotic, or those under the influence. Instead, such behavior is inflicted at the hands of those who did not get what they wanted, were tired of waiting, missed their honey-bunny, thought it was too noisy at the nurses’ station, or whatever flavor of the week it was.

Isn’t it sad that healthcare, an industry genuinely dedicated to helping others and on the forefront of fighting domestic violence, finds itself in an abusive relationship as well, to the extent that some of its practitioners find themselves justifying the violence and siding with those who are abusive toward us?

Objectives

1. Participants will be made aware that the current path healthcare is being “taken down,” with regard to customer satisfaction, is NOT good for healthcare and could even incite healthcare-directed violence.
2. Participants will appreciate that by putting healthcare and healthcare workers first and customer satisfaction as a follow-on factor, everything else will fall into place, which includes customer retention, profits, and, most significantly, a safer workplace.

Methodology

“The Customer is NEVER Right: A Nurse Practitioner’s Perspective” is neither research nor the words of a disgruntled healthcare worker. Instead, it is the story of so many in healthcare and a story that had to be told. A story penned as the testament of one man’s struggle to maintain his integrity and keep his job while pointing out the serious problems between healthcare administrators and the status of healthcare, but ultimately failing, at least in terms of keeping his job.

This work is a telltale record of a nurse practitioner’s experience working in multiple pressured environments, emergency care, family practice, and occupational health, in urban, suburban and rural settings, and in the communities of the haves, the have not, and the more common potpourri of everything in between, where, increasingly, patients have EXAGGERATED UNREALISTIC EMOTIONAL EXPECTATIONS.

Findings

- Healthcare is the only industry with patients. NO other industry can make that claim.
- Customer experience and satisfaction scores are NOT about healthcare.
- There is NO correlation between satisfaction scores and good healthcare.
- Customer service is the driving force in healthcare without accomplishments.
- Healthcare is our greatest silent national crisis because of its overwhelming collateral damage and healthcare-directed violence, yet, so many look away.
- Customer satisfaction scores perpetuate a culture of EXAGGERATED UNREALISTIC EMOTIONAL EXPECTATIONS.

- Healthcare is more expensive and of inferior quality today when comparable to before ALL the money, time, and effort wasted on chasing satisfaction scores.
- Healthcare-directed violence has become more frequent, more brazen, and more violent despite being studied extensively.
- Conflict resolution and aggression management policies are IMPOTENT and are no more than “feel good” legislation.
- Despite ALL the “talk” about healthcare-directed violence, reports from victims continue to be greatly underreported.
- The perfect storm—healthcare’s submissive, altruistic, and accommodating culture, the unchallenged focus on customer service, EXAGGERATED UNREALISTIC EMOTIONAL EXPECTATIONS, and healthcare’s lack of leadership.
- Healthcare, despite being on the frontline of the fight against domestic violence, finds itself in an abusive relationship too, which includes justifying the violence of and siding with those who are abusive towards us.
- Other healthcare organizations are labeled as the competition “up the street” rather our treasured colleagues helping others as well.
- The literature, professional and lay, is inundated with articles that suggest why rating healthcare is bad for everyone’s health, both patients and healthcare, yet no one is interested.
- Healthcare lacks the leadership needed to make real change and no one wants to tackle it alone.
- It is frustration and NOT fatigue as to why so many leave healthcare.

Implications

The only restoration possible for the damage already done is to take healthcare back from those who have taken healthcare down the wrong track and ensure that our profession is pointed in the right direction. A direction that promotes healthcare workers as valuable and trustworthy, supports our collaboration and professionalism, and recognizes us as good-doers over concerns that patients may take their business elsewhere. In order to get there, healthcare needs a seismic paradigm shift rather the current idiot-ology [sic] of nibbling at the edges of the problem. And it must be a daring shift that will deflate customer service in healthcare to nothing more than a byproduct of healthcare rather than its driving force. In order to accomplish such a dismissal of previous idiot-ology [sic], healthcare needs change agents willing to go in a new direction, even alone. In other words, as Albert Einstein told us, “We cannot solve our problems with the same thinking we used when we created them.” Meaning, we must rid ourselves of traditional thinking before we can create the future. We can no longer hang on to a mistake JUST because we spent a lot of money, time, and effort making that mistake.

First, healthcare must put its submissive, altruistic, and accommodating ideology aside and see itself as exceptional to other industries and understand why healthcare cannot be likened to other industries. Healthcare is not only an industry dedicated to helping others but more importantly, healthcare is a time-honored profession trusted with the obligation of saving lives and stomping out disease. Not to mention, healthcare is the only industry with patients and no other industry can make that claim. On top of that, healthcare is the only industry in which services are sought during some of the worse moments of our lives and during inconvenient times, for uncertain, unpredictable, and volatile choices in places that are unknown, unpleasant, and unforgiving. It is the only industry where, regardless of disposable income or time, services are sought after and rendered. The only industry where workers are extensively vetted before being trusted with doing our jobs despite having attended accredited schools, being finger-printed, being recertified every year for one thing or another and undergoing credentialing at least biyearly to ensure we did not commit some wrong doing our employer was not aware of. The only industry whose workers maintain the public’s confidence year after year as the public has recognized us as the most honest profession and with the greatest ethical standards of any industry. Most notably, healthcare is the only industry where workers go to battle for every “so-called customer” and when “so-called customers” succumb, we cry for them as well.

Second, healthcare workers, unlike workers of other industries, advocate for patients, promote health, prevent illness and injury, and maintain levels of health for others while placing patients’ reasonable concerns ahead of our personal convenience, pleasure, profit, and safety without bias, stereotype, or compromising the contributions of colleagues or peers with whom we must stand in solidarity. To do so we must be allowed to cultivate our profession and steer it in the right direction.

Because of that healthcare must NEVER be cheapened to being just another industry and much less at the cost of so much.

Disagreement is NOT a hate crime or a crime at all. Nor is it a lack of compassion or of caring either. But, accommodating patient complaints and focusing on customer satisfaction scores comes at the cost of

healthcare needs. In contrast, what and would benefit the most would be if we invested all our energy, time, and money into clinical outcomes and the safety of healthcare workers and patients.

To do so, we must dismiss those who annoy us. Dismiss the rude, the entitled, the abusive, the demanding, and those who tread on us. By dismissing those who annoy us, we are freed to focus on those who value, trust, and appreciate us for the care we give. On this point we MUST stand in solidarity and NOT waiver, otherwise those who annoy us will not change their behavior as long as they can find tolerance elsewhere. Pandering is not advocacy. Neither is accommodating, placating, or appeasing. If anything, indulging those who make unreasonable demands on us leaves us vulnerable.

Above ALL, we must side in loyalty with our employees and coworkers over petulant, unreasonable, angry, and demanding patients or outsiders who will harm us if we do not submit to their EXAGGERATED UNREALISTIC EMOTIONAL EXPECTATIONS. This is not about us versus them but about convincing them we are looking out for their best interests and if they desire our help, they must stand with us. If they decline, they must leave. Because asking to be catered to until they get what they want is manipulative and NOT what we are here for as it only divides healthcare workers trying to help others.

On top of that, the ill or injured must NEVER be seen as clients, customers, or guests but as the patients they are, ill or injured. Not to mention, NO other industry has patients and in this we are unique so why not embrace that uniqueness rather call them clients, customers, or guests as they are labeled in other industries.

Lastly, because healthcare administrators, pundits, and outsiders will push back on this provocative paradigm shift of taking healthcare back and steering it in the right direction, where healthcare workers and the care we provide must come first and be followed by customer satisfaction, we must push back even harder, taking no prisoners. Because of that, this is NOT a task for a person to tackle alone, but of companions standing in solidarity across healthcare lines and across geographic borders.

Proposals

1. Rid ourselves of traditional thinking to create the future.
2. Deflate customer service to a byproduct and not the driving force of healthcare.
3. Promote leadership.
4. Endorse healthcare workers as valuable and trustworthy.
5. Ensure no one gets fired because of customer dissatisfaction.
6. Put the clinical outcome and safety of healthcare workers and patients first.
7. Dismiss those who annoy us.
8. Consistently take the side of employees and coworkers.
9. NEVER see the ill or injured as clients, customers, or guests.

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Learning objectives

Participants will...

1. be aware that the current path healthcare is being “taken down” with regard to customer satisfaction is NOT good for healthcare and incites healthcare directed violence.
2. appreciate that by putting healthcare and healthcare workers first and customer satisfaction to follow everything else will fall into place, to include customer retention, profits and, most significant, a safer workplace.

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Violence against women during childbirth in healthcare settings: a concept analysis

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Obstetrical violence, health care, childbirth, conceptual analysis

Background

The emerging literature on perinatal mortality presents compelling evidence: many women experience disrespect or mistreatment when they give birth at a health care facility [1-4]. In the province of Québec (Canada) and around the world, women and women's rights groups are increasingly complaining about violence during childbirth [5, 6]. Nevertheless, the concept of obstetrical violence (OV) has received little attention in the scientific and medical literature [7-10]. Instead, some authors address more specific behaviors and practices such as abuse [1-3], mistreatment [11], disrespect [2], maternal distress [12], negligence [13], or dehumanized care [3].

In order to define the attributes of this emerging concept, improve our understanding of it, and contribute to its operationalization in research and clinical practice, we conducted a conceptual analysis inspired by Walker and Avant's (1994; 2005) method, in which we integrated a feminist analysis [14].

Methods

We reviewed relevant articles published in the last 20 years as well as papers issued by various groups that promote reproductive health and the defence of women's rights, in Canada and internationally. The following databases were searched: MEDLINE, ERIC, ÉRUDIT, CINAHL, PSYCINFO, Cochrane, Social Science Index, MIDIRS, and ISI Web of Knowledge. Selected articles had to: 1) be written in French or English, 2) present quantitative or qualitative data concerning OV or related health care concepts, 3) be published in the period from 1995 to 2015. Article references were retained in order to identify additional publications. A total of 38 documents, including 22 articles published in peer-reviewed journals, were retained for the analysis of empirical referents.

Results

Uses of the concept of obstetrical violence. Currently, the term obstetrical violence (OV) is used mainly by citizen action groups working to defend women's rights. It is rarely used or defined in the scientific literature, the medical and legal fields, or the humanities and social sciences. Three countries have operationalized this concept in their legal systems by incorporation into laws to protect women during childbirth. In Venezuela, the law respecting violence toward women includes article 51, which describes the behaviors by health care professionals that are considered acts of OV [15]. Argentina has drafted a law that prescribes three criteria to ensure humanizing treatment for all women: respectful medical practices, women's participation in the decision-making process, and the promotion of natural childbirth [16]. The state of Chiapas (Mexico) has enacted a law that specifically targets OV. It prohibits the appropriation of a woman's body by dehumanizing treatment, including abuse in terms of the medicalization or pathologization of natural childbirth [17]. In Belgium, an association for citizen education proposed that, "Medical interventions that are not scientifically valid and are practiced without the informed consent of women during pregnancy and childbirth must be recognized as obstetrical violence" [our translation] (Braun & Lalman, 2014, p.62).

Attributes of obstetrical violence

The attributes of OV were drawn from the above-described analysis of the literature research. They represent the characteristics that were consistently mentioned in association with the research object [18].

1. Women suffer from or experience distress following childbirth.

The OV experience harms women and jeopardises their physical, moral, and psychological integrity [19, 20]. Women report recurring nightmares, depressive episodes, and suicidal thoughts [8]. Some report feeling like a “piece of meat” or “separated from parts of my body” (e.g., during forced rupture of the membranes) [8, 21]. Women may feel psychologically damaged, particularly because they feel discredited, with no control over their own body [21]. This can cause them to doubt themselves and their capacities as a woman and as a mother [7, 21].

2. Obstetrical practices violate the principle of informed consent.

One of the issues concerning respect for women during childbirth is the requirement for informed consent. Informed consent implies that 1) the patient must be informed, 2) she must be able to hear or receive the information, and 3) she must understand the information and express that understanding [22]. In medical practice, “therapeutic privilege” is used only when doctors believe that the person under their care is psychologically or physically unable to handle information about their health or treatment. However, the literature provides ample evidence of medical procedures, and particularly those involving the vagina during childbirth (e.g., episiotomy, vaginal examination) that are performed without disclosure or consent, regardless of whether or not the woman is able to provide her informed consent [23]. Women have described these procedures as intrusive and non-consensual.

3. The woman’s reproductive agency is not recognized.

In broader terms, agency refers to the capacity to act in a competent, reasonable, conscientious, and reflective manner [24]. In the OV situations identified in the literature review, women’s intentions and choices about their own childbirth are rarely or not taken into account by health care professionals, even when it is possible to do so (e.g., walking during the active work phase, giving birth in a crouched position) [8, 21]. Furthermore, the symptoms that women feel are often ignored or must be validated by health care staff with instruments (e.g., fetal monitor) [8, 10, 21]. Thus, women’s autonomy and right to self-determination are not recognized [16].

4. Obstetrical violence is recognized to varying degrees across individuals, and depending on circumstances and cultures.

To date, publications have characterized OV as subjective, albeit based on an objective factual reality [16]. Accordingly, what a woman perceives as violent may not be perceived as such by her partner and entourage; what a woman and her spouse perceive as violent may not be perceived as such by the caregiver; what a hospital caregiver may perceive as violent may not be perceived as such by the professional staff of another facility; and what a particular culture perceives as violent may not be perceived as such by another culture. The literature presents few tools for operationalizing OV, which means that the primary analysis filter remains the subjective experience of the women who give birth and other parties who are directly involved (e.g., partner or spouse, medical staff). Nevertheless, the literature provides some guidelines as to whether or not the provision (or withholding) of medical childbirth procedures should be considered violent. In a systematic review of the literature on mistreatment during childbirth, Bohren and collaborators identified several categories of experience: physical, sexual, and verbal abuse; stigma and discrimination; failure to meet professional standards of care; poor rapport between women and providers; and health system conditions and constraints [11]. Jewkes and Penn-Kekana [25] propose two underlying dimensions of these categories: 1) intentional use of violence (physical and verbal abuse, stigma), and 2) negligent withholding of care or failure to provide needed care, and structural disrespect.

Antecedents. Antecedents are “those events or incidents that must occur prior to the occurrence of a concept” (Walker & Avant, 2005), and which increase the risk of occurrence.

1. Women are the ones who give birth.

Up to now, women are the ones who give birth. Accordingly, female and male bodies are governed by social constraints as well as gender, racial, cultural, and class norms [26]. This has produced a paternalistic attitude on the part of health care staff toward women’s sexuality and reproduction, such that males are given decision-making power over women’s health, to the detriment of women’s right to choose how they give birth [22]. The severity of discrimination against women depends on ethnicity, age, socioeconomic status, and medical condition [4, 11].

2. The vision and conception of childbirth as a medical procedure: women are “delivered” of the baby.

The belief that childbirth is a medical procedure is historically situated: at the close of the 18th century, when health care systems began to regulate childbirth, almost all women gave birth in medical facilities rather than at home [27]. As delivery came under the control of doctors and as obstetrical advances were developed

mainly by men [28], women's knowledge of their own bodies became discredited [22], along with their knowledge of the physiological processes of childbirth [29]. This paternalistic and patriarchal medical model consequently reduced women's power and the power of their body over the birthing process [29].

3. The hierarchical relationship between women and professional caregivers

In the hierarchical relationship, there is little or no collaboration between the doctor and the parturient woman concerning her participation in the decision-making process [8, 22]. This lack of collaboration takes the form of "authority," whereby the caregiver assumes the power to make decisions [1, 9, 11, 20, 30, 31]. This handover of power to medical staff is perpetuated when, having placed her trust in the attending doctor, the parturient woman complies with prescribed procedures without question [22]. A hierarchy is therefore established, imposing a power imbalance in the health care system that is consistent with the surfeit of power that doctors enjoy [8, 20, 22, 30].

4. Failures of health care systems

Structural failures observed in health care centers mean that women do not receive optimal care, particularly when the staff are overworked [20]. Such circumstances can cause frustration, which affects professional practices and contributes to the mechanization of care [20, 30]. Bohren and collaborators [11] revealed a multitude of health care system failures associated with mistreatment: poor supervisory structures, insufficient staffing, inadequate supply chains, and poor physical conditions and policies for women giving birth. This complex range of systemic failures tends to be invisible when it becomes the norm.

Consequences

Individuals. Individuals who have experienced OV may suffer from post-traumatic stress symptoms [8, 9, 16, 21], emotional distress [8, 30], frequent panic attacks [8], feeling abused [8], and feeling invisible [8]. Higher stress and anxiety have also been observed [8, 16, 20]. In addition, after childbirth, some women report recurring suicidal ideas, depressive symptoms, or depression [8]. Women may also feel deceived, powerless [30, 32], angry, or guilty [8, 30, 32]. Women also report feeling loss of autonomy and control [8, 11, 20, 21, 32].

Families and couples. The relationship with the baby can be affected, particularly when the mother rejects the baby [21], distances herself from the baby [8], or blames the baby for the negative childbirth experience [8]. In contrast, some women become overprotective of their baby [8]. The parental couple can be affected, notably when one partner does not understand the other. Women may avoid sexual relations for fear of getting pregnant again [8].

Health care systems. To avoid being humiliated or hurt once again, some women will refuse to use the health care system for subsequent pregnancies [11, 21]. They may lose confidence in the health care system and make fewer visits to health care centers.

Definition of obstetrical violence

Based on the various referents considered in the conceptual analysis, we propose the following definition of OV: In the health care field, obstetrical violence includes professional practices that occur, or are withheld, during childbirth without the informed consent of the woman giving birth, implying non-recognition of her reproductive agency. This systemic violence is created and reinforced by power imbalances that condition the childbirth and cause women suffering and distress. The forms, the recognition, the impact, and the scale of this violence vary across individuals, settings, and cultures.

Discussion

Obstetrical violence (OV) remains a rarely used term, and the issue has received little attention in the research on violence during hospital delivery. Depending on the circumstances, it has been variously called mistreatment, disrespect, or negligence by health care professionals. However, OV has characteristics that differentiate it from these other terms. We therefore felt it appropriate to conduct a literature-based conceptual analysis to target this type of violence.

This study includes some limitations that should be mentioned. First, health care systems differ according to geographic location, with large variations across countries. Consequently, the components of OV proposed here may not be representative of all possible OV situations. Second, the literature on which the conceptual analysis was based comprises published works. The quantity, and more importantly the quality, of the available material are directly related to the ability to identify the components of OV. Although all our reviewed publications met the established selection criteria, we were aware that important references

could be missing. Furthermore, there is a potential bias due to publication in academic journals. Despite these limitations, the strength of the conceptual analysis lies in the proposed framework, which provides a better understanding of this emerging issue by shedding light on gender-related violence and the structural violence that is superimposed. In the identification of published works on this issue, we noted the lack of a common vocabulary to describe this type of violence against women. We hope that our conceptualization of the behavior and our proposed definition will enable the operationalization of this form of violence against women. Nevertheless, some questions remain. Some of the reviewed articles addressed the intentional nature of OV [33, 34]. Even though OV does not necessarily stem from the desire to harm others, it is characterized by the intention to disrespect individual choices. Some articles consider this power relationship between the health care professional and the woman. It is denounced as a double loss for women: loss of control over their childbirth and loss of confidence in their ability to give birth [8, 21, 23, 28, 31]. Accordingly, it would be instructive to conduct further studies in health care professionals to explore their perceptions, their experiences, and the consequences for their birthing practices.

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Learning objectives

Participants will...

1. appreciate that violence during childbirth is an emerging issue that needs our attention.
2. understand violence during childbirth as an evolving concept, as its definition is closely linked to the emerging literature in this field.

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Reporting on Violence: Data Integration and Reporting Across the Healthcare Sector in British Columbia, Canada

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Incidents of violence, reporting, data integration

Background and context

Capturing the different situations in which violence in the healthcare workplace can be observed, experienced and reported can be challenging. Between patient safety reporting systems, interventions provided by Security Services, and the requirement for reporting workplace injuries, there are many ways in which incidents of violence can be reported. This also creates many ways for the data to be captured and categorized in the different systems. This paper describes how the health authorities in British Columbia, Canada, worked together to create the first comprehensive and inclusive report of violent incidents across the entire province. This paper represents half of the larger project of integrated reporting of violence in the healthcare workplace in British Columbia. The other half of the project is focused on provincial reporting on education and training rates, and is presented separately.

Methodology

Working closely with the occupational health and safety leadership teams in each health authority, key contacts were identified for each data system. Once contact was made, interviews were conducted to determine if other local systems existed that needed to be included. Also, clear understandings were achieved relative to how, when and where data were captured were obtained from the data stewards. Once data were received from each data steward, data cleansing efforts were applied and inconsistencies were identified and addressed. Data transformation measures were applied to the different data sets as required to ensure a consistent event categorization across all data sets. Once the data were sufficiently cleansed and adequately re-coded, the data were combined to provide reports to the client groups for their internal purposes. After revisions were applied, the report was finalized and published.

Findings

Challenges were encountered in consistently defining an event – violence directed toward healthcare workers – consistently across all three data sets. This was further challenged by the fact that one of the data sets had contributions from four different systems from across the province, resulting in four different methods for categorizing the same type of events. Additional issues were identified regarding how each data set is populated, which led to questions regarding in how to best represent the data. In the end, the efforts, while substantial, were determined to be very worthwhile. The stakeholders valued the efforts made, and the end result was a relatively complete report on violence in healthcare across the province. Further discussion and investigation is required to determine the extent to which the data sets can be integrated and represented as a “complete” picture of violence in the healthcare workplace.

Learning objectives

Participants will...

1. understand the challenges involved in harmonizing different data sets to report on similar types of events.
2. appreciate the efforts required in integrating disparate data sets for the purposes of comprehensive reporting on violence in the healthcare workplace.

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Does Training Make a Difference? Initial Findings of Relationship Analyses Between Data Sets for Violence Prevention

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Prevention, violence, associations, correlation analysis

Background and context

Education and training has been one of the primary means of mitigating risk of violence incidents in the healthcare workplace in British Columbia, Canada. Through focused efforts of all the Health Authorities in British Columbia, movement forward has been achieved in ensuring the healthcare workers most at risk for workplace violence have received the provincially-standardized training. Through an associated project, provincially-standardized reports have been created that provide rates of completion of the required education and training by high-risk program in each Health Authority in BC. Combined with the rates of violence incidents against healthcare workers, it is possible to examine the point-in-time relationship between the provision of training and the rates of incidents of violence. This paper provides the initial findings of the correlation analyses performed on these two data sets, namely the completion rates of education and training and incidence of violence by healthcare program. It was expected that the greater the completion rates, the lower the incident rates.

Methodology

Data were collected and assembled into a consistent data set to describe incidents of violence against healthcare workers and education and training completion rates, by healthcare program (Emergency/Urgent Care, Mental Health/Addictions/Substance Abuse, Residential/Long-Term Care). Correlation analyses were conducted on the data as of December 2015. The findings were examined for their R-squared values.

Findings

Seven health authorities combined to provide a range of 1-3 program data points to the entire data set; six organizations provided data for all three programs, and one organization provided only one. When all programs were plotted together, a weak R-squared value resulted ($R^2=0.07$). However, substantial differences were observed once the data for each program were plotted separately. Residential Care had almost no association between the data sets ($R^2=0.01$), Mental Health and Addictions had a stronger association ($R^2=0.46$), while the data for the Emergency Departments/Urgent Care Clinics had a very strong association ($R^2=0.69$). The relationships identified in the Emergency and Mental Health groups were both inverse; that is to say, the higher the completion rates for education and training, the lower the incident rates of violence against healthcare workers. These data are cross-sectional comparisons only, and as such, inferences are limited. It does, however, identify the possibility of quantifying the relationship between the provision of education and training to healthcare workers and the reduction of violence against healthcare workers.

Learning objectives

Participants will...

1. understand the extent to which the provision of education and training is associated with rates of violence incidents in different care environments in the healthcare workplace.
2. become aware of the issues they may want to consider when designing an evaluation framework for their own violence prevention programs.

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Workplace Violence faced by Doctors in a rural tertiary hospital of Central India: Pattern and Intervention

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Violence, doctors, pattern, intervention

Background and context

India is the second most populous country in the world with 72% of its population having a rural background. The health facilities are relatively inadequate for the population at large & more so in the rural areas. Our hospital is a 1500 bed general hospital in central India catering to the needs of the surrounding rural population. Attempts have been made to make the services cost-effective and yet, not compromising on the quality of services. Lack of awareness, poor financial condition, low literacy rate, prevalence of superstitions & the tremendous belief in faith healers causes the service users to be preoccupied on many occasions with the outcome of treatment & its need for cure. They tend to suspect the doctors intentions in this regard. Hence, on many occasions hospital stay seems to be prolonged, chances are that relative & friends may become violent. A poor outcome after treatment also triggers violence. The treating Physician or the surgeon is subjected to violence ranging from verbal abuse to physical assault. Impatience on the part of the patients & their relatives also result in such violence. Hence, study to assess the pattern of violence faced by the doctors in our setup. We would like to assess the data & see what is the most common form of violence used & how could we minimise it so that the doctors may be able to work in a fearless environment & provide the best of healthcare services to its service users. We would see if there is more violence towards a particular gender of doctors of a particular speciality. In Psychiatry and Emergency medicine departments, violence is generally assumed to be more than others, hence this study. Finally we would like to assess as to how we can minimise all such violence and make the work place environment safe and violence free.

Methodology

Study Site : Department of Psychiatry ,Acharya Vinoba Bhave Rural Hospital and Jawaharlal Nehru Medical College; Type of study: Cross sectional; Subjects: Doctors involved inpatient care from various departments; Type of sampling: Purposive; Total number of subjects : 60; Duration of study: Data was collected between 1st January 2016 to 20th February 2016; Instrument Used : Workplace Violence in Health Sector country case study –Questionnaire.

Inclusion criteria

1. Subjects consenting to be a part of the study and willing to provide unbiased view via the answers in each section of questionnaire.
2. Subjects with a minimum of 1 year of experience in the hospital setup.

Exclusion criteria

1. Subjects with less than 1 year of experience in the setup.
2. Subjects not willing to be a part of study.

Findings

Currently, data has been collected from 60 doctors involved in the hospital for more than 1 year. The statistical analysis is underway and we expect to be ready with the results and their inferences by the 10th of March 2016. However, it seems from the data that the subjects have mostly faced psychological violence and less of physical violence, the details of which will be made available after complete statistical analysis.

Learning objectives

Participants will...

1. get to have an understanding of types of aggression encountered by Doctors in a rural setup of central India.
2. also be able to identify the factors causing such violence & strategies that need to be adopted to solve such violence.

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Workplace Violence faced by Nurses in a rural tertiary hospital of Central India: Pattern and Intervention

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Violence, Nurses, pattern, Intervention

Background and context

The Nursing staff is the back bone to any health facility. In no situation, their role can be undermined in treating and healing a patient. A holistic treatment care is impossible without the valuable contribution from the Nursing staff. Be it the Intensive Care Unit or the Day care centres, the role of a Nurse is vital. A good nurse with his/her ability to care does not only delivers a doctor's prescribed medication to the patient, but often counsels them, empathises with them and lends an emotional support to the patient and their family members. Often it is seen that as the Nurses are more involved with the patients and relatives who are admitted, they are the once to face violence on a more regular basis. A nurse's job is varied. From providing appointments to engage the patients while they wait for the doctor to collecting samples to dispensing prescribed medication to nebulizing or conduct catheterizations. In our scenario, where the availability if trained staff is scanty and work load being high, violence is often encountered by the Nurses. Interaction of a nurse is often more with an admitted patient and this often results in both landing up in a relation of mutual respect or the one of extreme hatred resulting in mild to extreme violence more from the patient or their relatives. On many occasion, the female Nurses also have to face Gender discrimination and explicit comments on the part of the few of the relatives as the hospital set up is rural with poor awareness and understanding. Many even consider the nurse as a barrier between the patient and the doctor leading to some sort of violence towards the Nurse. Hence, we decided to take up a study to assess the pattern of violence faced by the Nurses in our setup. We would like to assess the data and see what is the most common form of violence used and how we could minimise it so that the doctors may be able to dispense best healthcare services to its service users. Finally we would like to assess as to how we can minimise all such violence and make the work place environment safer.

Methodology

Study Site : Department of Psychiatry ,Acharya Vinoba Bhawe Rural Hospital and Jawaharlal Nehru Medical College; Type of study: Cross sectional; Subjects : Nurses involved inpatient care from various departments; Type of sampling: Purposive; Total number of subjects : 60; Duration of study: Data was collected between 15th January 2016 to 15th February 2016; Instrument Used : Workplace Violence in Health Sector country case study –Questionnaire.

Inclusion criteria

1. Subjects consenting to be a part of the study and willing to provide unbiased view via the answers in each section of questionnaire.
2. Subjects with a minimum of 1 years of experience in the hospital setup.

Exclusion criteria

1. Subjects with less than 1 years of experience in the setup.
2. Subjects not willing to be a part of study.

Findings

Currently, data has been collected from 60 Nurses involved in the hospital for more than 1 year. The statistical analysis is underway and we expect to be ready with the results and their inferences by the 10th of March 2016.

Learning objectives

Participants will...

1. learn about the prevalence of aggression against Nursing staff in our hospital setup.
2. learn about common types of aggression encountered on day to day basis and the most violent forms of aggression encountered.
3. learn about the Reason for such violence at the setup.
4. learn about the Strategies that need to be adopted to address all such issues and minimise such occurrences.

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Workplace Bullying: Descriptive Analysis of Incident Reports in a Large Hospital System

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Workplace violence, bullying, healthcare workers, hospitals

Background and context

Bullying is a recognized occupational hazard in the healthcare sector, but most current knowledge is based on small-scale, cross-sectional studies. In the scientific literature, bullying is defined as worker mistreatment that occurs repeatedly, may be threatening, humiliating, or intimidating, and may sabotage one's work. This study aimed to identify the characteristics of bullying incidents, targets, and perpetrators drawing from a database of system-wide incident reports documented by hospital employees.

Methodology

The study was conducted within a multi-site hospital system with a central, standardized system for recording workplace violence incidents and related injuries. Hospital system employees are expected to report both physical assault and non-physical acts of violence, including verbal or emotional abuse and harassment. However, the reporting system offers no specific definition of bullying. Between 2010 and 2015, a total of 79 incidents reported by hospital employees as bullying were documented in the electronic reporting system. Incident descriptions were de-identified by hospital system data analysts. Descriptive content analysis was used to identify common characteristics in the bullying incidents. Two researchers independently read and coded the incidents for common descriptive categories.

Findings

Of the 79 documented incidents, 18 (23%) fit the definition of repeated abusive conduct and were coded as "bullying." Over half of the incidents ($n=45$, 57%) described behavior that did not occur repeatedly and was not always directed towards any one person; such incidents were coded as "general unprofessional behavior." A subset of these were categorized as hostile behavior ($n=8$, 10% of the total number of incidents). These were categorized by extreme verbal aggression, screaming, and nasty remarks; most of these incidents described hostile behavior by an individual directed towards a group of employees, frequently medical residents. Remaining incidents, comprising 10% of the total sample, were directed at specific targets and were categorized as harassment (4%), verbal abuse (3%), threats (2%) and discrimination (1%). Nearly half of all reported incidents failed to identify the job category of the target and/or the perpetrator. The most prevalent job categories of targets that were reported were nurses (20%), patient care associates (11%), or allied health professionals (10%); most common perpetrators were nurses (19%), managers or administrative professionals (8%), and patient care associates (6%). Documented incidents described employee reactions of fear for their own safety, sadness, frustration, and fear of patient safety being jeopardized. Some employees reported that they had changed work units due to the unprofessional behavior that they had experienced.

Implications

Only one quarter of the incidents reported by hospital employees as bullying actually comprised repeated, abusive conduct. Results suggest that clear definitions of bullying and other forms of worker-to-worker mistreatment in hospitals are needed, so that appropriate interventions can be developed.

Learning objectives

Participants will...

1. identify some of the most common categories of documented worker-to-worker events that employees themselves describe as bullying.
2. identify the job categories of both the targets and perpetrators of workplace bullying in a hospital setting.

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A user-friendly system for reporting violent incidents in the Emergency Department: An Italian experience

Sub-theme: Aggression and/or violence toward staff or service users

Poster

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University of Florence, Firenze, Italy

Keywords: Under reporting, Emergency nurses, Workplace Violence, Smartphone app, Report-keeping system

Background and context

Violence against health workers is a worldwide phenomenon. Nurses, especially those of the Emergency Department (ED), above all if engaged in triage, are among the most exposed workers. Italy is not immune from the problem, so much so that the Ministry of Health issued in November 2007 a specific 'Recommendation to prevent acts of violence against health workers'. Since 2006, Workplace Violence (WPV) in Health Sector is considered a sentinel event.

The analysis of the ministerial reports published to date, shows that the phenomenon of violence against Italian emergency nurses is growing. Despite recording systems (report-keeping) and monitoring of the WPV are becoming more common, the under-reporting of violent incidents, widely described in the literature and estimated at around 80%, remains today a major obstacle to the knowledge of the problem and a limit for the actual verification of the effectiveness of interventions to prevent, counter or minimize the phenomenon. Recent studies suggest that the use of simple and easy recording systems may facilitate the reporting of violent events. This research aims to study the effectiveness of a simple system (user friendly system) reporting acts of violence to the emergency nurses via smartphones in comparison to reporting /recording by paper for incident reporting ad hoc in use at the Perugia's Hospital (Italy). The primary endpoint of this study is demonstrate that the use of friendly system for reporting can reduce the under-report.

Methodology

The 16 items reporting form, in use at the ED of Perugia (An third level emergency department, with 65,000 access/year) was reproduced in an application for smartphone, tablets and PCs. Will enrol all of Perugia ED nurses, who claim to have suffered at least one episode of violence, during the first six months and 12 months of 2016. Informed consent for study participation and the delivery of Information form on respect for confidentiality and the treatment of data, it is expected. The data will be compared using parametric tests. During monitoring of aggressive events in our ED, in place from 28 May 2010 to date, we have been carried out two surveys (April 2013 and November 2015) addressed to the nursing staff concerning the reporting of aggressive events in the last year. In April 2013, 29.6% of the victims reported only 'some' episodes, while 62.9% none. In November 2015, 17.7% some episodes, 70.6% none.

Findings

This survey will be repeated, to compare previous data.

Implications for practice, research, education & training, organisation / management, policy and guidance.

The expected outcome is the decrease of under reporting of violent incidents.

Learning objectives

Participants will...

1. appreciate how user friendly reporting system is.
2. learn that the system can reduce the under-reporting phenomenon.

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Changes in violence against doctors in Norway between 1993 and 2014

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Qualitative research, aggression, workplace violence, primary care, risk factors

Background and Context

Several studies have concluded that doctors are at risk of being victims of workplace violence. There is a general belief that the problem is increasing. A Japanese study reported higher prevalence of violent work experiences among general practitioners, psychiatrists and emergency medical doctors, compared to doctors in other specialities [1]. Studies from Japan, Australia and New Zealand have indicated that younger doctors are more exposed than older, and that men seem to be more exposed than women [1-3]. So far, most studies have been limited to one part of the health sector or measurement at a single point in time. More knowledge is needed about how the prevalence of violence against doctors changes over time, and if there are differences between subgroups of doctors. Thus, the aims of this study were to describe changes in prevalence of violence against Norwegian doctors from 1993 to 2014, and to investigate associations between experiences of threats or violence, and age, gender and medical speciality of the doctor.

Methodology

A nation-wide postal survey was sent to an independent, random sample of Norwegian doctors in 1993 and 2014 [4, 5]. The two questionnaires addressed different topics, but questions regarding age, gender, specialty, threats and violence were identical in the two surveys. Threats was measured with the question 'Have you experienced threats of violence from patients or other "visitors"?', while violence was measured with 'Have you experienced violence from patients or other "visitors"?' In addition, fear of violence was probed with the question 'Have you during the past year felt that you was physically or mentally unfit due to fear of being exposed to violence at work?' Response categories were: "No", "Yes, once", "Yes, two or three times" or "Yes, more than three times". Descriptive statistics were given by percentages. The outcome measures of self-reported experiences of being victim of physical threats or violence at work were dichotomized into yes and no, and analyzed by log-binomial regression, estimating relative risk (RR) and 95% confidence interval (CI).

Findings

The number of doctors responding to the survey were 2628 (response rate 72.8%) in 1993, and 1157 (response rate 74.9%) in 2014. The results from the descriptive statistics and the regression analyses will be presented at the conference.

Discussion

Strength and limitations

The strength of the study is that two independent, relatively large groups of randomly chosen doctors were asked identical questions with a twenty years interval, and the response rate was good both years. A weakness of the study is that the questions regarding experienced threats and violence were not limited to a given period in time.

Implications for practice

The knowledge about changes in violence over time, as well as identifying the doctors who are most at risk, may give a better basis for choosing preventive actions against workplace violence.

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Learning objectives

Participants will...

1. have an understanding of the prevalence of violence among doctors in Norway during a 20-year period.
2. learn which sub-groups of doctors are at risk.

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Implementation of Safewards in a collaboration between an open and closed unit, with an aim to decrease violence and threats, as well as reduce the use of coercive measures

Sub-theme: Aggression and/or violence toward staff or service users

Poster

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Keywords: Implementation of Safeward strategies

Abstract

When a patient first arrives on one of the units, a collaboration-plan will be developed by the welcoming nursing staff. An individual action-plan for unpleasant situations will subsequently be developed, based on both the collaboration-plan and the patient's Brøset Violence Checklist (BVC) tendencies. The action strategies will then be further developed and implemented based on the Safewards philosophy. The patient will take an active part in developing both plans. We will create safe, transparent and coherent treatment-plans, also focused on patient involvement, hoping to develop a common use of nursing treatment-plans across the two units. The units will also develop a strategy regarding the possibilities of temporarily exchanging staff members between units, thereby ensuring the continuous presence of relevant competence in both units. This is anticipated to be most relevant in the days around an inter-unit transfer. The staff's specific knowledge of the patient is relevant in the work of de-escalation and prevention of violence when patients are in a new environment. Safewards interventions will be implemented in several areas of care, with the aim of enhancing personal qualification, which will led to a noticeable reduction in violence and aggression and the data will be documented on a daily basis.

Method

We will follow the process of the BVC tendencies, the use of restrain and who the staff members rate their occupational satisfaction, as well as the sick leave measured over a year.

Results

Preliminary result will be presented on the poster at the conference

Learning objectives

Participants will...

1. be aware of and get an understanding of how Safewards becomes a primary and permanent part of the units' daily relational treatment.
2. will get an understanding of how we implemented the Safeward concept

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Early relation between patients and staff can possibly reduce violence and threats in a psychiatric unit

Sub-theme: Aggression and/or violence toward staff or service users

Poster

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Keywords: Early relation, psychiatry, violence, threats, staff, User involvement

Introduction

The aim is to establish an early relationship between patients and staff in order to prevent violence and threats.

Background

User involvement is increasingly prioritized in the psychiatric field, as well as in general psychiatry and in forensic psychiatry. Patients has often aired a wish to be included in processes taking place in the departement and to have more responsibility and influence. To create an early relationship between patients and employees this project was therefore initiated.

Methods

In order to include the patients, a quantitative survey is conducted to explore whether the patients had appetite to participate in the project. As patients responded positively, the project was initiated in September 2013 and was terminated mid-June 2015. The patients participated in the hiring of new employees, which meant that the patients attended the employment interviews together with three permanently employed personnel. Finally, a questionnaire was made focusing on patient's perception and their view on whether there were differences between those employees they had been involved in hiring and the rest of the employee group.

Results

From the results it appeared that patients experienced a significant difference, that they knew the new employee and that they have had a share in the process and they thereby felt accepted and respected. The patients felt less stigmatized and was generally more positive. 80% of the patients wished to continuously participate if possible. The fact that the patients were allowed to formulate own questions was a huge advantage, as they did not feel controlled. In the same period as the project was completed, we made an observation of a diminution of violence and threats in our departments.

Conclusion

Due to the early user involvement in the employment interviews in our psychiatric departement, patients experienced more positive interactions with the staff. In the same period we observed a decrease of violence and threats in the departement. There may be a connection between the user involvement and the reduced violence and threats.

Learning objectives

Participants will...

1. have an understanding that positive user involvement might reduce violence and threats in a psychiatry department.
2. learn that the majority of the patients involved in the employment interviews would like to participate in forthcoming interviews.

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Experience of violence among Thai health service users under Health Insurance Universal Coverage Program and expected Quality of Care

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Health Insurance Universal Coverage Program, violence, expected quality of care, Thailand

Abstract

Thailand has been remarked as a country with highly successful in Health Insurance Universal Coverage Program (HIUCP) and high satisfaction level of health service users. However, very little studies had been conducted regards to experience of violence user faced in health care facilities though this experience has been counted as an index of Quality of Care (QOC). This study aimed to identify violence experience in health care facilities of Thai HIUCP service users and its relation to expected QOC.

A province in the central part of Thailand was purposively selected. Then, a district of the province was randomly selected. A proportional household sampling was conducted to interview head of households or representatives who are under HIUCP of that district. A structured interview was carried out by health volunteers who were trained for project objectives and interview techniques.

Totally, 345 household were interviewed during June – November 2013. Variables which had been included in the questionnaire were: Socioeconomic and demographic characteristics, type of hospital registered, traveling time, waiting time, whether suffering with any chronic illness, experience in hospital visit, experience in medical errors and expected QOC etc..

It was found that 15% of Thai HIUCP service users faced with verbal/physical aggression during their hospital visits. These aggressions were inflicted either by hospital staffs or other clients and their relatives. This experience was significantly related to level of income, waiting time, experience in medical errors and expected QOC.

These findings pointed that health service users with differences of income level, amount of waiting time, experience in medical errors and level of expected QOC tended to face with aggression in their service uses.

Health care policy makers should aware that equity in accessibility to health service is inadequate if service users are still facing with violence in health care sector. Prevention and reduction of aggression in health facilities should be developed, particularly, in developing countries where awareness in this issue is very low. It should be born in mind that violence in health care sector has a high impact to QOC at last.

Learning objectives

Participants will...

1. have an understanding of the violence faced by service users under Health Insurance Universal Coverage Program in a developing country and can compare it to the service users in their own countries.
2. be able to discuss prevalence of violence among service users and experience in medical errors and expected QOC of patients in Thailand.

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The Importance of Violent Behaviour Assessment at Admission of Psychiatric Patients to the University Psychiatric Hospital Ljubljana

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Mental disorder, admission, nursing care, violence

Abstract

Introduction: Providing for the safety of patients and staff is the highest priority task of those employed in psychiatric hospitals. The use of assessment checklists for evaluating violent behavior is recommended. The aim of this article is to show the usefulness of the Brøset Violence Checklist (BVC) in providing for the safety of patients and healthcare providers.

Method: This study is based on quantitative, non-experimental methods using a retrospective analysis of the quality indicator: »Demandingness of Admission to the University Psychiatric Clinic (UPC) Ljubljana.« The sample included 3060 recorded patients admitted to the UPC Ljubljana, representing 76% of all admitted patients. Data were analyzed with the help of descriptive statistics, Pearson's correlation coefficient, ANOVA, the chi-squared test and the Kendall test ($p < 0.05$).

Results: During admission of a patient with mental disorder who has a BVC score of 3-4, it was determined that at least 2 extra nurses are needed ($p < 0.05$), while for patients with a BVC score of 5 - 7, additional help from police was required ($r = -0.496$; $p < 0.000$).

Discussion: On the basis of the BVC assessment, the type of intervention required to provide for the safety of patients and staff can be reliably confirmed. The results may also provide a basis for improving healthcare interventions during admission of patients with mental disorder, as well as helping with the organization and planning of staff. The BVC is therefore recommended for further use.

Introduction

Admissions to the University Psychiatric Clinic Ljubljana (hereafter: UPC Ljubljana) are most frequently due to an acute state, a deterioration in the mental disorder or a crisis state. It is generally well-studied and well-known that staff in acute psychiatric hospitals often deal with violent patients and consequently with various violent measures (Shakya, *et al.*, 2008; Novak Grubič, 2010; Knutzen, *et al.*, 2013). Violence, or rather aggression, has a number of definitions. In the narrow psychopathological sense, violence includes deliberate or careless harm or destruction of one's self, others or things and is linked with negative emotions such as anger, fear, despair, rage and hatred (Kores Plesničar, 2006). In terms of violence, the most high-risk groups of patients are characterized by the following: male sex, age, being single, social isolation, alcohol abuse and previous suicide attempts (Kores Plesničar & Kordič Lasič, 2004). Violent behavior by a patient in a psychiatric healthcare environment is treated as an urgent case requiring the highest professional performance by the healthcare team based on their experience in clinical practice coordinated with timely action in order to prevent or lessen the violent behavior and its consequences (Lapanja, 2012). Cowman and Bowers (2008) warn that the problem of violence in psychiatric institutions should not be underestimated, as the consequences are felt most strongly by the staff. Violence against healthcare staff is frequent and may lead to a negative effect on the quality of health care given (Clark, *et al.*, 2010). Violent events often result in serious consequences not just for patients but also for healthcare staff, therefore effective management of violence is important. Healthcare institutions should therefore have protocols and policies for preventing and managing violent behavior in place (Robida, 2004).

Brøset Violence Checklist - BVC

Predicting a potential violent situation has long been a challenge to healthcare workers in the field of mental health. At UPC Ljubljana in 2012, we began to use a structured assessment tool to predict violent

behavior, i.e. the Brøset Violence Checklist or BVC, which was published by Almvik and Woods (1999). The BVC is based on an assessment of the most frequent forms of behavior seen prior to violent events. It is used during patient admission or later (on the ward). The BVC is completed by a person who is part of the medical team and is trained in how to complete it (Abderhalden, 2008). Experience from clinical practice has shown that the BVC assessment is of greatest importance in predicting the signs of risk for the appearance of violent behavior within the first 24 hours of admission (Almvik, *et al.*, 2000). The aim of introducing the BVC was to offer staff a tool that would help predict the potential danger of the development of violent behavior not only in known patients but also in those being admitted in psychiatric hospital for the first time (Clarke, *et al.*, 2010). From an analysis of the checklist we can understand how violent behavior in an individual may change with regard to its form or intensity (Gabrovec, 2014). It was determined that use of the BVC is an effective tool for the fast prediction of violent behavior because it gives medical staff the ability to act in a timely manner. As a consequence, it decreases the likelihood of an undesired outcome (Abderhalden, 2008). The checklist is easy to use and allows a single assessment of the situation and thus easier communication about the patient between staff, shifts and institutions (Almivik & Woods, 1999; Almivik, 2008).

The aim of this study was to determine the usefulness of the BVC in ensuring the safety and security of medical staff and the safe and secure medical treatment of patients with predicted violent behavior. We posed the following research questions to ourselves:

1. Do the scores on the BVC predict the need for additional medical staff?
2. Does a BVC score of 5-7 when admitting a patient with mental disorder mean that we need the additional help of the police?

Methods

This study was quantitative and non-experimental in nature.

Description of a sample

The total sample group included all patients admitted in 2014 ($n = 4026$). The actual sample group analyzed was 3060 (76 %) of the recorded admissions to the Center for Clinical Psychiatry (CCP), which is one of the organizational units of the University Psychiatric Clinic Ljubljana. The rest of 24 % admissions we could not include because of the lack of data.

Description of the research instrument

For the purposes of this study we created Tables 1 and 2 where all data on the admitted patients was inputted on the basis of the examined admission documentation for all 3060 recorded admissions.

Description of the research procedure and data analysis

An analysis of internal indicators of quality called »The Demandingness of Admission to the UPC Ljubljana« was carried out in which the following information was entered for each patient admitted: patient, without signs of violent behavior, verbal violence, bodily violence, BVC assessment, help from other people (number of people), help by police, constraint measures used, recorded incident, injury to staff. The data were recorded by the admitting or on duty RN s at the CCP at the UPC Ljubljana. From 1. 1. 2014 to 31. 12. 2014, 3600 admissions were recorded into the register. The data were then entered into tables for statistical analysis. We carried out the following statistical tests: descriptive statistics, Pearson's correlation coefficient, ANOVA, the chi-squared test and the Kendall test. We also took into account the statistical relevancy of the results such that $p < 0.05$.

Results

Table 1 shows the general data for the internal indicators of »The Demandingness of Admission to the University Psychiatric Clinic (UPC) Ljubljana« in 2014. Table 2 shows the distribution of patients by score on the BVC, as assessed at admission. In 2014, according to the assessment of RN (as evidenced in the »The Demandingness of Admission to the UPC Ljubljana«), »verbal violence« ($n = 148$) was expressed most frequently by patients while »bodily violence« less so ($n = 42$). Medical staff responsible for admission made the most use of »help from medical staff from the department/ward« ($n=409$). For the remaining data see Table 1.

Table 1: Evaluation of "the demandingness of admission"

Criteria for demandingness of admission	n
Verbal violence	148
Bodily violence	42
No signs of violent behavior	2870
Help from medical staff from the ward/ department and the number of them	409
Help from police	242
Incident during admission	12
Special security measure	90
Bodily harm to employee	3

Legend: n = number of patients

As shown in Table 2, during admission the majority of patients received a score of 0 (n=2671, 87.2%), the next greatest number of patients (n = 104, 3.4%) were given a score of 1, meaning that their risk of violent behavior was increased and preventive measures were needed, this was followed by patients with a score of 2 (n = 92, 3 %), patients with a score of 3 (n = 80, 2.8 %) and so on.

Table 2: BVC Assessment

BVC assessment	n / %
0	2671 / 87,2
1	104 / 3,4
2	92 / 3
3	80 / 2,8
4	41 / 1,3
5	40 / 1,3
6	16 / 0,5
7	16 / 0,5

Legenda: n = number of patients; % = percentage; BVC 1–2 = The risk of aggressive behavior is increased; preventive measures are necessary. BVC ≥ 3 = The risk of violent behavior is very high; preventive measures are necessary and an individual plan for managing potential violent behavior should be in place.

From Table 3 it is evident that there is a very high correlation between the two variables - BVC and the help received from other people ($r = 0.938$, $p=0.000$). This correlation is positive, which means that as one of the two variables increases so does the other. In other words, as violent behavior increases the amount of help needed from other people also increases, or conversely as violent behavior decreases the amount of help needed from others decreases as well. Therefore, on the basis of the BVC score, we can reliably predict the need for help from other people in dealing with the patient.

Table 3: Correlation between BVC score and the indicator »help from other staff on the ward/department«

Help from other people (Number of people)		
BVC (Brøset Violence Checklist)	Pearson's Coefficient Correlation	0,938**
	p	0,000
	N	3034

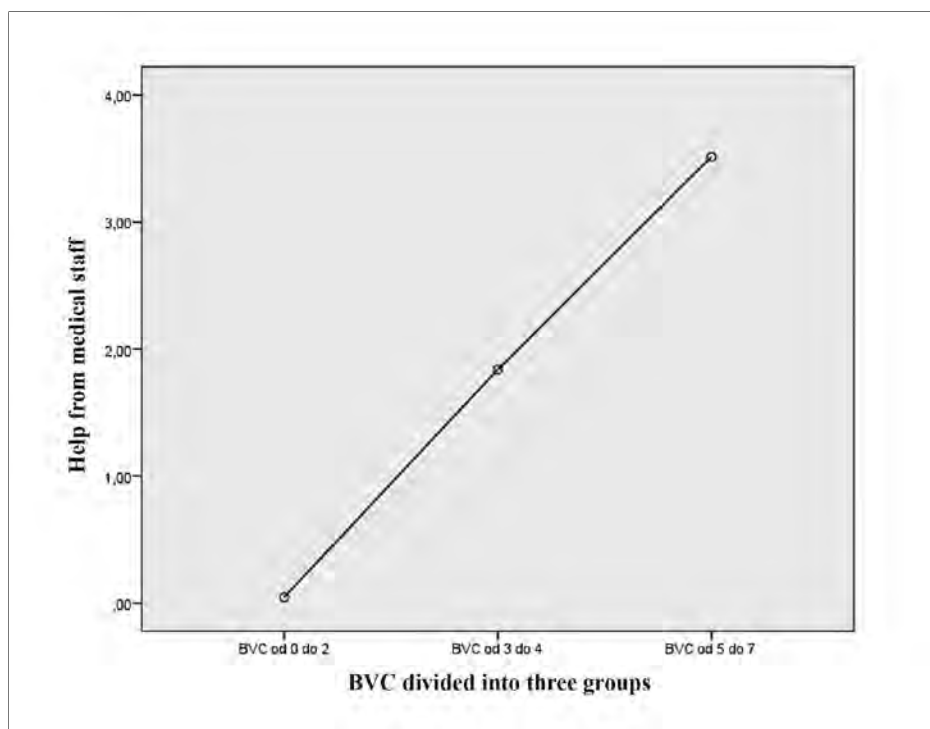
Legend: ** = $p < 0.05$

The BVC (Brøset Violence Checklist) assessment can be divided into three groups depending on the amount of help required from other people:

- First group: 0 to 2;
- Second Group: 3 to 4;
- Third Group: 5 to 7.

This was followed by application of the Brown-Forsythe test, by which we determined the statistically significant difference between the three groups. The analysis showed ($F = 978,708$, $p=0.000$) that there remains a statistically significant difference ($p<0.05$) between the groups. In the second group, for example, an average of two people were needed to help.

Figure 1: Help from medical staff according to the assessment of BVC scale



Using correlation analysis and ANOVA we can therefore predict that a BVC score of 3-4 during admission of a patient with mental disorder will require the help of two additional people. Using the chi-squared test, we tested whether there is a correlation between the indicator »help from police« and the BVC score. Using the Pearson's chi-squared test ($p=0.000$), we determined that there was a statistical difference between the groups with regard to the BVC score and the »help from police,« as shown in Table 4.

Table 4: Correlation between BVC score and the indicator »help from police«

		3 categories of BVC score			Total
		BVC 0 to 2	BVC 3 to 4	BVC 5 to 7	
Help from police	yes	126	67	57	250
	no	2704	70	21	2795
Total	2830	137	78	3045	

We then applied the Kendall test in order to determine the direction and strength of the correlation. The correlation is of medium strong and negative ($r = -0.496$; $p < 0.000$), which means that for a large proportion of patients with mental disorder, the larger the BVC score, the greater is the need for help from the police. Using the chi-squared test and the Kendall test, we can therefore predict that we will need help from police when admitting a patient with mental disorder with a BVC score of 5-7.

Discussion

Ensuring the safety and security of patients and staff represents one of the most important interventions in psychiatric health care. Jansen *et al.* (2005) determined that violence during the admission of patients with mental disorder is directed at medical workers so often that employees have come to think of it as being »part of their job.« In order to successfully prevent violent behavior in psychiatric health care it is important to understand all of the risk factors and circumstances that increase the danger of aggressive behavior appearing. Here is where there is an important role for the use of checklist assessments in determining the risk of violent behavior. It is important for assessment checklists to be easy to use, quick to fill out and to have a good predictability value. The research literature on this topic suggests that a combination of descriptions of aggressive behavior with regard to the type and intensity of numerical factors (BVC score) in current clinical practice shows promising results. At UPC Ljubljana, the number of undesirable events and the number of BVCs filled in shows that the use of the checklist prevents the escalation of aggressive behavior and with that the number of undesirable events. The usefulness of the checklist in terms of the planning and organization of staff also confirms the research. We have determined that on the basis of the BVC score we can predict the number of additional people needed to help with a patient. A BVC score of 3-4 during admission of a patient with mental disorder will require the help of 2 additional people, while a BVC score of 5-7 during admission of a patient with mental disorder will require additional help from police. In a large percentage of patients, an increasing BVC score increases the number of special security measures needed, the need for additional help from the police and a detectable increase in violence on the part of the patients. While in a very small percentage of patients it is possible on the basis of the BVC score to predict the number of extraordinary events, injuries to staff and other incidents. The fact is that verbal and physical violence aimed at medical staff by patients, as well as their relatives, is on the rise around the world as determined by Kores Plesničar and Kordič Lasič (2004), although they claim that there are various reasons for this. These reasons are often dependent on the specificities of a given population, while the consequences of violence are the same everywhere. Therefore, in Slovenia it would be necessary to give more attention to this problem and on the basis of the evidence gathered about violent incidents against medical personnel to prepare recommendations for recognizing, controlling and preventing violent incidents in healthcare institutions.

Conclusion

The Brøset Violence Checklist or BVC is one of the most helpful tools for predicting the occurrence of violent behavior in patients with mental disorder and its use improves both the quality and safety of medical treatment.

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Learning objectives

Participants will...

1. appreciate the practicality of Brøset Violence Checklist for ensuring patient and staff safety in nursing care.
2. learn that various cut-off points on the Brøset Violence Checklist may influence the choice of intervention.

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Sexual Harassment Against Female Nursing Staffs in different Hospitals of Kathmandu, Nepal

Sub-theme: Aggression and/or violence toward staff or service users

Workshop

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Keywords: Sexual Harassment, Nursing, Patients, Co-worker

Abstract

The issue of sexual harassment on nurses at the workplace is gaining gradual recognition as a problem of discrimination against women as workers at the workplace. It is an issue that interfaces with two concerns: violence against women and rights of women in the workplace. Patients, their relatives and co-workers are considered as main perpetrators on this issue.

This study aimed to access the magnitude and prevalence rate of this problem, its characteristics and consequences among the nursing staff of Kathmandu working in hospitals. A descriptive cross sectional study was carried out among 114 nurses of different hospitals using a semi structured self-administered questionnaires.

With the response rate of 85.96%, 72.44% of the respondents had experienced the sexual harassments during their nursing career. The most common form of harassment was sexual teasing and jokes (43.9%) followed by unwanted telephone calls (35.36%) and pressure for date (23.17%). The co-workers and doctors are the most common perpetrators followed by the patient relatives and patients. The most common form of immediate response on the action was ignoring the behavior (43.9%), avoiding the person (17.07%) and joking about the action was 13.41%. 95.12% of the respondents claimed the decrees in work productivity due to the harassment. 86.58% of the respondents had discussed the incidence with the friend of same hospital. 2.43% of the participants had complained the incidence with the management of hospital. None of participants had taken the training on safety measures on the harassment.

The prevalence rate of sexual harassment among female nurses are extremely high in least developed country like Nepal which leads to significant decrees in the work productivity as well as increase psychological effects on nurses hence the protective legislation and measures should taken by the hospital management and government for the prevention of this problem in future.

To evaluate the prevalence and trend of sexual harassment among the female nurses in different hospitals of Kathmandu.

Learning objectives

Participants will...

1. learn about the prevalence and trend of sexual harassment among the female nurses in different hospitals of Kathmandu.
2. learn about the major perforators for the sexual harassment.
3. understand the characteristics and consequences among female nurses due to the sexual harassment.

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From 'fat cows' to physical attacks: Assault against public servants leading to sentences to psychiatric treatment

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Mentally disordered offenders, Assault against public servants, Forensic Psychiatry in Denmark

Background and context

Violence and threats against public servants have significant attention in the general public discourse and plays an important part in the ongoing discussion of possible explanations for the recent strong growth in the number of sentences to psychiatric treatment in Denmark. Since the millennium, the number of individuals sentenced psychiatric treatment or placement has tripled from 1445 to almost 4400 mentally ill offenders between 2001 and 2014. The annual number of new sentences to psychiatric treatment or placement has been between 600 and 750 over the past ten years. The proportion of sentences on the bases of violence and threats against public servants (Danish Penal Code §119) has increased dramatically, from 5% in 1980, to approximately 25% of the annual numbers of new sentences to some kind of psychiatric measure in 2014. Studies show that physicians, nurses and social and health care assistants most frequently are victims (Danish Ministry of Health 2015: 'Kortlægning af retspsykiatrien', Report by a Group of Experts).

Methodology

This is a sub-study on a larger mixed method study, comprising all patients treated in one out of two specialized forensic outreach teams (ForACT) in the Mental Health Services in the Capital Region of Denmark over the period of 7 ½ years (2006 – 2014) (n=181). The sample is based on data from medical records, including psychiatric assessment reports and verdicts. Data concerning previous and present psychiatric history, criminal records, socio-demographic background etc. are electronically stored and statistically analysed. Qualitative research methods are used to analyse the contents and contexts of the §119-cases.

Findings

The types of assault against public servants in this sample are diverse, varying from mockery, verbal threats to physical attacks and severe injuries. Displaying complexity and diversity, the mentally disordered offenders (MDO) in this study are generally characterised by significant social problems, severe mental illness, comorbidity, and an extensive criminal record. The MDO's in the sample who have been convicted according to §119 are even more heavily burdened than the MDO's never convicted for assaults against public servants on a range of parameters: e.g. crime onset; type of committed crime; frequency of psychiatric hospitalisation. The diversity and complexity of the §119-cases will be illustrated by a number of cases.

Implication for practice and research

Assaults against public servants take place in social situations. Research that analyse the complexity and diversity of these situations and relations provides a better basis for developing preventing strategies and conflict solutions.

Learning objectives

Participants will...

1. be aware of the need of a contextualized understanding of assaults against public servants.
2. get a better understanding on the possibility to prevent assaults against public servants.

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Reducing Inpatient Violence in a Maximum Secure Setting: Lessons Learned from Examinations of the Acute Risk of Violence Scale

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Inpatient Violence, Risk Prediction, Major Mental Illness, Psychosis

Introduction

Violence is common in psychiatric settings and can result in injury, stress, anxiety, and psychosomatic illness in inpatients (Berg, Olsen, Sveipe, & Holy, 1994). During their career, more than 90 percent of physicians and nurses working in psychiatric hospitals will be victims of patient violence (Benjaminsen & Kjaerbo, 1997). Forensic hospitals house patients in the mental health system requiring the highest level of security due to their propensity for violence and are therefore likely to experience higher rates of inpatient violence compared to general psychiatric settings.

In an attempt to reduce violence, most forensic facilities use a measure of risk for imminent inpatient violence. In our maximum secure facility, the *Acute Risk of Violence Scale* (ARVS – see Figure 1) was created by combining adapted items from commonly used, empirically supported, inpatient risk for imminent violence measures. The ARVS was intended to be used to estimate the risk of inpatient violence and is also used to inform a privilege level system of patient area access (including, on unit, common area, vocational, and recreational areas) and personal property. However, no psychometric examinations of the measure had been conducted prior to the current investigations and there had also been anecdotal reports of staff dissatisfaction with the measure and privilege level system

This paper describes our strategy for examining the utility of the ARVS and the resultant changes to inpatient risk of violence assessment and privilege level system. First, we conducted a staff survey to determine how the measure was implemented on the various programs and to examine staff satisfaction with the measure. Next, we had staff concurrently score the ARVS, the *Brøset Violence Checklist* (BVC; Woods & Almvik, 2002), the *Dynamic Appraisal of Situational Aggression* (DASA; Ogloff & Daffern, 2006), and then used these scores to predict incidents of patient aggression to determine accuracy. Finally, based on the research we conducted and informed by stakeholder consultations, we revised the way the ARVS was being used and the patient privilege level system.

STUDY 1. Survey of Staff Satisfaction with and Use of a Risk for Imminent Inpatient Violence Measure

Method

Participants

Staff working in our maximum secure forensic setting completed a questionnaire on their use and views of the *Acute Risk of Violence Scale* (ARVS) on SurveyMonkey® or by paper and pencil. A total of 85 respondents completed the survey which represents approximately 30% of the total available staff. There was no significant difference in the response rate by discipline (RN, RPN, Allied Health, Security), $p = .23$. Anecdotal reports suggested the low response rate was due to staff belief that their input would not result in any changes. Both the high rate of violence and a staff perspective that their concerns were being ignored, lead to a sense of helplessness and hopelessness among staff working directly with this highly dangerous client population. The maximum secure forensic hospital setting described in this paper houses approximately 160 men who have typically been found to be not criminally responsible for their, often very serious, offending due to a mental disorder. This facility is the only maximum secure facility serving an area with a population of approximately 13 million and therefore gets the most problematic and dangerous forensic patients, including those who are refractory to medical treatments and those patients whom were unable to be managed safely in a less secure setting. Although, not all forensic patients are violent in hospital, the current setting has a disproportionately high percentage of these patients.

Results

This survey revealed significant staff dissatisfaction with the ARVS, with 88% of staff respondents saying that violence toward staff had either not changed (45%) or had increased (43%), and only 12% reporting a decrease in violence since its introduction. However, a more careful examination of the results primarily showed staff dissatisfaction with the ARVS's connection with the patient privilege level system. Nearly 70% of staff said the ARVS could help prevent inpatient violence, but only 16% said that it could effectively inform the patient privilege level system.

STUDY 2. Predictive Accuracy of Three Measures of Risk for Imminent Inpatient Violence

Method

Participants

The participants in this study were the staff on two of eight units in the maximum secure forensic facility completing risk for violence scoring on 37 male forensic patient residents.

Measures

Three short-term risk for imminent inpatient violence assessment measures, the *Acute Risk of Violence Scale* (ARVS – see attached), the *Broset Violence Checklist* (BVC; Woods & Almvik, 2002), and the *Dynamic Appraisal of Situational Aggression* (DASA; Ogloff & Daffern, 2006), were completed over a period of one month on two of eight units at the maximum secure forensic facility. The ARVS was scored three times per week (Monday, Wednesday, & Friday) as per policy, and the BVC and DASA were scored daily, as per recommended use. Once this data was collected, we then accessed the facilities' electronic violent incident reporting system to see which measure best predicted inpatient violence.

Results

The BVC and DASA predicted patient perpetrated violence as well as they typically do in published reports (e.g., Chu, Dafern, & Ogloff, 2013), with AUCs in the .72-.79 range (high predictive ability – see Rice & Harris, 2006). However, the ARVS (AUC = .85) predicted significantly higher than either the BVC or the DASA. While this would seem to be a good result as the ARVS appears to be predicting patient violence very well, it certainly does suggest the response to the prediction (i.e., the patient privilege level system) is not mitigating risk. If the ARVS predicts inpatient violence well and the response to that prediction is effective, then the ARVS should have a low AUC because the potential for an incident was identified and the response to that prediction should have ameliorated the possibility of an incident. Unfortunately, this is not what was found. Consequently, there was a need to revise the patient privilege level system.

STUDY 3. Revision of Privilege Level System Based on Research and Stakeholder Input

The final step we have taken, to date, in our attempt to improve staff and patient safety is to revise the use of the ARVS and the patient privilege level system. In order to consider as many aspects of change as possible, we first conducted 36 engagement sessions with staff of all disciplines, patients, and other stakeholders, including a further survey of staff concerns. In this survey there were 200 survey completions, representing a 66.4% response rate suggesting strong staff interest in revising the privilege level system. Further, engagement sessions were well-attended and typically generated lively discussion. Based on feedback from staff, patients and other stakeholders, and due to the litigious nature of some of our more personality disordered patients, ethical and legal consultations were also conducted. Due to the laws in our setting, it was determined that the privilege level system must not in any way attempt behaviour modification as its goal without the consent of the patient. Therefore, the privilege level system focused on allowing patients as much liberty as possible while ameliorating risk of violence. This is of particular note as many staff expressed a desire for a system that would provide consequences for misbehaviours. Our legal consultant reported that a system that had overt behavioural control or consequences for misbehaviours that appeared to be an attempt to modify behaviours would not withstand a legal challenge.

The previously unaddressed issues highlighted by our research and the staff, patient, and other stakeholder consultations that needed to be dealt with in the new level system were: 1) patient risk for elopement; 2) a separation of area access privilege from patient personal property privilege; 3) the ability to tailor risk predictors for each patient, if necessary; 4) recognize and have the ability to tailor privileges to the unique characteristics of patients on different units; and, 5) a need for patients to demonstrate ability to successfully manage their current privilege level prior to being given greater privileges. Other considerations that needed

to be addressed when implementing the new violence reduction strategy were: the need to score the risk for violence measure daily rather than 3 times per week as the measure is based on others that were designed to be 24-hour predictors (Almvik, 2002; Ogloff & Daffern, 2006); and 2) the need for increased and improved empirically-based psychotherapeutic treatment to address known risk factors for violence (Barnao & Ward, 2015).

Results and conclusion

Although the new privilege level system has been designed and implemented, the long-term effect of this new system on the reduction of violence in this facility has not yet been determined. However, research is underway to examine the frequency and intensity of violence post the introduction of the new system and will be reported shortly. The above examination strategies and solutions are presented in order to assist other facilities facing similar issues and to inform those interested in research on the reduction of inpatient violence in secure forensic facilities on strategies we used. We have and continue to face many challenges in attempting to reduce violence in our setting, such as staff motivation and sense of helplessness, patient resistance, management and government sense of urgency. However, in order to be recovery focussed and improve quality of life for both patients and staff, we are committed to looking at every possible strategy to reduce the impact of violence.

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Learning objectives

Participants will...

1. appreciate the importance of being evidence-based when attempting to reduce inpatient violence.
2. learn of a strategy for examining the efficacy of strategies to reduce inpatient violence.
3. gain knowledge on a mobility and patient personal property privilege level system based on the results of research which contributes to a least restrictive but safe environment for patients and staff.

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Self reporting system of aggressions: a useful tool for workers, managers and occupational health professionals

Sub-theme: Aggression and/or violence toward staff or service users

Workshop

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Keywords: Aggression, Health care workers, Occupational Health Services, Violence, Work, Occupational, Surveillance, Hospital

Background and context

In 2010 the executive management team of a main health provider of the national health system in Barcelona (PSMAR), with a catchment area that includes one of the poorest areas of the city, approved the policy “Zero Tolerance” to prevent violence at work, proposed by PSMAR Committee for the Prevention of Violence at Work. Several actions were agreed including surveillance and preventive measures. A new online reporting system of violence incidents was proposed as it was perceived that only a small minority were registered through the occupational injuries reporting system.

Methodology

PSMAR is a public health provider with a workforce of around 3.500 professionals, distributed in acute and long-term care, mental and primary health, health care training and research centers. The study population includes all workers who reported one or more aggressions against them during their work in 2015 through the newly established online self-reporting system of aggressions. It was developed in 2013 within the hospital information system for clinical and administrative management, and piloted during 2014 following an internal campaign. After an incident, the worker is prompted to fill in a simple online form. An automatic email is then sent to the Occupational Health service (OHS), the worker is contacted by phone and a second online part is then completed to gather detailed information on the aggression, its potential prevention and need for worker’s support. Most managers and supervisors have access to the registry as well. An analysis was carried out of data registered during 2015.

Findings

Between January and December 2015, 102 aggressions were reported involving 81 workers from 35 different services/units. Ten workers reported 3 or more aggressions, and 20 aggressions came from one single service/unit. Time to reporting was 0 days in 79 (77.5%) cases and 18 (17.6%) within the first week after occurrence. More than half (65.7%) of aggressions were verbal (insults, threats, etc.), 13.7% were physical, 10.8% verbal and physical and in 6.9% a threatening object was shown or used. In 65 (63.7%) it was the patient and in 14 (13.7%) one or more relatives who assaulted the worker. Eleven cases (10.8%) were notified as occupational injuries, and 3 of those were on sickness absence. Main underlying factors were the attitude of patients or relatives (66.7%), poor satisfaction with information or care received while in the hospital (14.3%), no respect to rules (6.9%) and long waiting time (4.9%). Proposed preventive measures were training (29.4%), registering patients/relatives associated with serious violence (11.8%) and safety guards (10.8%). No more than 25 aggressions per year were reported before 2014.

Implications

The new self-reporting online system for reporting aggressions against health workers has been found an easy and useful tool to the workers, OHS and the Committee. Managers are increasingly involved as well, though a focused intervention is needed. Some improvements have already been proposed before it can be reliably used to evaluate the effectiveness of interventions and conduct applicable research.

Learning objectives

Participants will...

1. have a basic understanding of a useful surveillance system of aggressions against workers in the health care sector.
2. understand how to develop and implement such self reporting online registry.
3. be able to analyze the data and information collected in the investigation of aggression that were self reported by health care workers.
4. appreciate the challenges of involving managers in the investigations of aggression.

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Crisis Response Team Look Back: Calls for Help Increase; Restraints Use Decrease: Is Violence Increasing or are We Better at Recognizing, Intervening and Preventing?

Sub-theme: Aggression and/or violence toward staff or service users

Poster

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Keywords: Agitation, aggression, restraints, need for humane innovation

Background

Violence in the health care setting continues to escalate as a public health issue, presents patient and staff safety issues along with ethical, professional and human rights concerns. Prevention strategies and effective interventions for agitated, threatening or violent patients remain challenging. Some US hospitals report increases in violence. Nearly six years ago our University Hospital (an urban, tertiary care, academic medical center) implemented Behavioral Crisis Response Teams (CRT) as part of an overall violence prevention program that includes general nursing department staff training in a variety of techniques. Our CRTs are Psychiatrists, Psychiatric Nurses, Nursing Assistants and Uniformed Public Safety Officers, who rapidly respond to overhead calls, pagers and cellphone alerts for safety concerns on the inpatient units; similar teams respond on the Inpatient Psychiatric Unit and the Emergency Department (ED). As in many hospitals, these calls involve a wide-range of patients from intoxicated substance users, the medically ill with delirium or dementia, aggressive and hostile individuals with psychiatric disorders (treated or otherwise), frank psychosis, those with anti-social tendencies, frustrated patients, perhaps in pain, families experiencing loss, grief, etc.

Methods

Data were collected from medical records, restraint logs and incident reports. We conducted a preliminary analysis comparing the first 36 months of the CRT program (June 2010 to June 2013) to the most recent 30 months ending with December 2015. The outcome variables of interest were techniques used to reduce violence: de-escalation, medication, physical restraints. Incidents were characterized as: threatening, agitated/confused, destroying property or, assaultive. Patient demographics and hospital location information were also collected.

Results

Restraint use is trending downward from mid-2010-2013 (46.8%) and mid-2013-2015 (43.43%) while crisis calls have increased (5.1/month v. 6.6/month). Overall, the psychiatric unit represents 15% of calls (34 beds out of 250 inpatient, 36 ED beds); medical/surgical units: 75% of calls and 10% from the ED. Nearly two-thirds of all calls (61%) were for male patients 18-44 years old; 10% were 65 years and older. Calls involving women are trending up (22% v. 36%). The most common reason for Crisis calls is agitation/confusion and has slightly increased (43% v. 46%). Further analysis will detail relationships among other variables: why some units have more calls or certain patient profiles are more vulnerable to agitation and confusion; characterize outcome relative to patient type and need.

Discussion

CRTs are a known resource to help mitigate or limit violence in healthcare settings. We are limited due to moderate compliance with full documentation of details. We see small gains, but it is uncertain if this intervention can really reduce restraint use. We need to try more refined, sophisticated and humane innovative interventions like new architecture with more environmentally calming amenities as well as meds and restraints.

Be aware that even highly trained and specialized teams may not be able to reduce restraint use under all circumstances

Learning objectives

Participants will...

1. realize that detailed, user friendly, reporting mechanisms to capture details of violent or pre-violent incidents are required to improve approaches.
2. think about innovate environmental calming measures that may include architecture, music, comfort amenities.

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Aggression and violence experienced by special needs assistants within Irish educational settings

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Special needs, Challenging behavior, Physical assault, Work absence

Abstract

Ireland has witnessed a paradigm shift toward inclusive practices in Irish education over the last 25 years since the Report of the Special Education Review Committee (1993) advocated the provision of education for students with special needs and with 'as much integration as is appropriate and feasible with as little segregation as is necessary'. This resulted in the education system meeting the needs of children and young persons with special needs within mainstream primary and post-primary school settings. The Department of Education and Skills provided increased resources to support this provision and a cornerstone of this support was the allocation of resource teaching hours and the introduction of special needs assistants within the classroom. Special needs assistants support pupils with a broad range of disabilities, with associated medical, sensory, emotional and behavioural needs.

One unanticipated outcome of this service transformation was the scale and magnitude of challenging behaviours including aggression within classrooms. This paper will present a large scale study undertaken to quantify this problem which utilized a purposefully constructed questionnaire to survey special needs assistants working within Irish primary and post primary schools.

The study revealed that in excess of 60% of SNAs had been physically assaulted, and 54% had witnessed a colleague being assaulted within the preceding 5 years, and for more than 90% of respondents being physically assaulted was a repeated occurrence. For some respondents physical assaults were a frequent occurrence with 40% of respondents encountering occurrences monthly and 18% daily.

Similar to findings within healthcare most assaults resulted in minor injuries only (85%). However 14% of assaults resulted in serious injury and 2% resulted in hospitalization. 30% of respondents had taken time off work directly as a result of being physically assaulted at some point during the preceding five years, and 20% of these absences were in excess of one month. Similar to previous research from healthcare settings, respondents were unsatisfied with organization supports provided following almost half of occurrences.

This paper will present the study in detail, with emphasis on the similarity of findings to previous research conducted in healthcare, and explore how the extensive research and learning from healthcare might be applied within educational settings caring for a group of children and young persons who were heretofore cared for within healthcare systems.

Learning objectives

Participants will...

1. have the opportunity to broaden their understanding of the similarities of aggression encountered within educational settings catering for children and young persons with special needs.
2. have the opportunity to explore the potential application of the extensive research and learning from healthcare within educational settings.

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Exploring the Lived Experiences of Nurses Bullied by their Co-Worker, Patients, and Patients Significant Others in Selected Hospitals in Metro Manila, Philippines

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Workplace Bullying, Filipino Nurses, Descriptive Phenomenology, Qualitative Research

Introduction and Background

Bullying has always have been a subject from various discussions and forums all over the world. A lot of measures and action plans had been proposed and implemented in the past and still continues up to this day, however, bullying has never come to an end. Bullying cannot only be seen in school's playground or in high school's quadrangle; it can also be seen in different places such as offices, grocery stores, public transportations, parks, hospitals, and other workplaces. Workplace bullying is currently one of the major challenges nurses' are facing nowadays. In fact, the Center for American Nurses (2008) stated, '*lateral violence and bullying have been extensively reported and documented among healthcare professionals with serious negative outcomes for registered nurses, their patients, and healthcare employers*', this only means that workplace bullying had been rampant already in various hospital in the United States and for sure all over the world whether small or large scale healthcare facilities.

The Philippines is one of the Southeast Asian countries that produce huge populations of nursing graduates per year. After successfully passing the licensure examination, nurses can be deployed in various hospitals around the country. Newly registered nurses in their first day of work are excited and anxious of what will be in stored for them. In the Philippines, the so-called '*seniority system*' (determines in the length of experience a nurse has, which makes a nurse powerful over the other staff members) has always been present in every healthcare institution up to now, although, nursing administration tries to abolish this informal designation of authorities and powers to senior nurses over the newly added nurses in the hospital. Sadly, no measures can eradicate this system because it is nature of Filipino professionals, not only nurses, to show and give respect to their seniors, because these people will still be their '*go to persons*' in their everyday workplace duties. Simons and Mawn (2010) investigated workplace bullying among the newly registered nurses through a qualitative research design, which they found out that workplace bullying resulted negative job satisfactions and retention. Not only newly registered nurses had been reported to experience workplace bullying, in fact, aging nurses in their late 50's and 60's have also been subjected for bullying. Nurses who had been subjected for workplace bullying by their co-workers, patients, and patient's significant others have these specific characteristics or criteria: racial stereotyping, socio-economic status, school and university affiliations, physical attributions, and gender preferences. With these given facts and arguments, the enormous questions are, how bullying can be eradicated in the workplace? How these nurses' experienced workplace bullying heal their wounded souls? What measures can be done to help bullied nurses? This qualitative study delved with the actual and witnessed workplace bullying experiences to understand this worldwide phenomenon that had never been put in to stop.

Methods

The research design of this topic utilized the qualitative descriptive phenomenological design. Phenomenology was chosen because it emphases in dealing with the lived experiences of nurses' experienced workplace bullying from co-workers, patients, employers, and patients' significant others. An author stated about this research design, '*Phenomenology is a philosophy and a research method designed to explore and understand people's everyday lived experiences*' (Abu Sosh, 2012, p. 31).

Moreover, this study focused in one grand tour question, '*what are the lived experiences of nurses' bullied in the hospital?*' The study was conducted with ten (10) nurses, no specific gender, who experienced bullying in all forms for more than two (2) years and been employed in the same institution for at least three (3) years

to show comparison on how bullying was dealt in their respective locales. Other criteria in selecting the participants were as follows: (1) willingness to share their lived experiences, (2) articulate in expressing their thoughts either in English or Filipino languages, and (3) availability for follow-up consultations and meetings.

The narratives of the participants were transcribed using tape analysis alongside the use of field notes (personal, transcript, and analytical files) to ensure the trustworthiness of the data. Semi-structured interviews were done 45 minutes to 1 hour and each participant was interviewed not more than three times. The study was conducted in the month of October 2015 and follow-up interviews were done to discuss the findings of the study and to make sure that it reflected their own lived experiences. Other methods included video calls; Skype, emails, and other multimedia were used to ensure the data saturation.

Collaizi's (1978) seven strategies of descriptive phenomenological data analysis was utilized to explicate the rich contextual narratives of the participants. It includes extraction, organization, and analysis of data to generate an exhaustive description concerning the phenomenon pertaining workplace bullying among nurses in the hospital. Significant statements were extracted from the transcript file to formulate contextual categories and cluster themes, which eventually lead to the construction of the emergent or overall themes that will represent and depict the lived experiences of the participants toward nurses' workplace bullying. To ensure the trustworthiness, rigour, validity, and reliability of this qualitative research in all aspects including data collection and data analysis, numerous methods were done like member checking (final validation from the participants), themes, theme clusters, and contextual categories were peer-reviewed by panel of experts, and translations were meticulously scrutinized by a bilingual translator to ensure that narratives were translated properly (Abu Soshia, 2012; Creswell, 2009; Creswell, 2003; Speziale & Carpenter 2007; Marshall & Rossman, 2006). Finally, autonomy and confidentiality were strictly imposed throughout the study.

Results and Discussion

Through the gathered narratives from the interviews conducted with the participants, significant statements were drawn and applied with the qualitative data analysis method of Collaizi (1978). Four (4) themes emerged from the lived experiences of the nurses' manifested workplace bullying. Each emergent theme will be discussed extensively in the next paragraphs with its theme clusters and formulated meanings supported by the participants' significant statements.

The Target: Ideal Victim of Nurses' Bullying

The first emergent theme depicted the kinds of nurses' who have been exposed to workplace bullying. From the formulated meanings generated from the significant statements, three (3) theme clusters were created: *age-related bias, social class discrimination and stereotyping, and individual differences*. Age-related biases refer to the unfairly treatment of a person or people discriminating certain age groups, which includes novice nurses who were newly licensed and employed nurses in diverse health care facilities and nurses in the mid-50s up to the retiring age, 60-65 years as mentioned by WHO. A study conducted by Simons (2006) revealed that majority of the bullied nurses' come from the population of newly licensed RNs. One female participant stated about age-related biases, which she experienced first-hand:

"I am newly licensed and hired nurse in a tertiary hospital in Manila. My first two (2) years had been the worst experience of my life. My co-staff nurses specifically the senior staff nurses always scold me. Instead of helping me learn the things I have to know, they make things complicated for me. Patients were hesitant to received nursing care because I am new. They believe I am not competent to do such interventions. The family of the patients often asked me where I graduated, how many years of experience, and sometimes request for a senior nurse to do the task instead of me. I often hear degrading comments about me being a novice nurse. I almost quit the job but I have no choice." (Transcript No. 2)

Another subjects for workplace bullying were nurses' discriminated and stereotyped due to their *social class* particularly when it comes to their races, religion, cultural, and socio-economical factors and nurses' *individual differences*. In the narratives, majority of the participants came from distant provinces that belong to the minority groups, different ethnicity and culture. Most of the time, they had been the subjects of malicious jokes concerning their naive customs and traditions. Cultural difference is one of the indicators how well health workers understand each other (Wachtler *et al.* 2006). Participants verbalized that some of the healthcare workers, hospital employees, patients, and patients significant others mimicked their native accents, bad intonations and mispronunciations to the point of humiliating the nurse in front of other people. Participants who experienced this felt disrespected and embarrassed resulting inability to perform their task well. On the other hand, individual differences pertain to the substantial variations concerning individual's character, behavior, intelligence, memory, or physical factors like size, shape, etc. However, every person is

created unique and different from each other. Nurses have certain distinct characteristics that separate from the rest, however, individual differences may be attributed as negative rather than positive. Some of the participants mentioned that *'being unique is being weird'*. Common target for workplace bullying in this theme cluster were nurses with weak personality, sexual orientations (third sex), physical attributes (too short, too big, or any body mutilations), poor job performances, etc.). A male participant uttered his experience about discrimination and individual differences:

"Most of the time my co-workers laughed at my native tongue's accent. They kept repeating my mispronounced words. They were not minding the people in the vicinity. Most of the time, I felt embarrassed. It's actually habitual lately. I am trying my best to ignore them but there were times it's already too much. I am also a human being and they have to respect and accept me for who I am." (Transcript # 12)

The Bully: The Art of Intimidating and Oppressing

The second emergent theme focuses on the proprietor of the act. Bullying as defined by Carbo & Hughes (2010) as *'behaviors can destroy the targets; dignity, self-esteem, confidence, and voice. The effects can be felt both inside and outside of work'*. Likewise, Juvonen & Grahams (2014) defined it as a habitual or repeated use of force, threat, or coercion to aggressively dominate, intimidate, and abuse others. Other definition includes *'repetitive behaviors of intimidating and oppressing people'*. Hence, anyone who exercises harm to others repetitiously can be called a 'bully'. Common examples of nurse bullying provide negative feedbacks for job performances of others to heighten their personal performance and *'being ignored and excluded'* resulting decrease patient outcomes and increase staff turnover and occupational stress (Etienne, 2014).

During the interviews, participants characterized various types of bullying they have experienced in their respective workplaces as identified by Berger (2014) such as: (1) *physical assaults and coercion* (using body), (2) *emotional, verbal harassments and threats* (uttering bad words, cursing, and even death threats), (3) *cyber bullying* (fallacious and malicious postings in social networking sites), (4) *relational* (destroy social standing of a person), and (5) *mobbing/ganging up* (collective bullying). All of these types may be experienced separately or in combinations depending on the extent of workplace bullying. A participant testified on his experience of cyber bullying stated:

"My patient and her family posted on my Facebook account their wrong accusations and bad experiences about my work as a nurse. It went viral and 'netizens' started to bash me for things I didn't do. I am receiving threats in my message inbox about the possibility of revoking my license. It was really a bad experience." (Transcript #4)

The Face Off: Confronting Dilemmas

The end results of workplace bullying among nurses depend on how the target will respond on the act of bullying. Simons (2006) determined that *ramifications of workplace bullying* include job dissatisfactions and intentions to leave work. Felbinger (2008) assumed that negative outcomes of workplace bullying among nurses lead to post-traumatic disorder and *'burned out'*. There were some studies hypothesized that undesirable consequences lead to depression, which can also progress in committing suicide and violence (Kim & Leventhal, 2008). One of the female participants uttered in a mellow tone:

"There was a time I don't want to report for work because almost everyday I overhear bad comments about me. I am sick and tired of their nagging and mischievous acts. I almost submitted my resignation letter to end this bullying." (Transcript # 11)

Support System from family, friends, groups, etc. can be a way to overcome the aftereffects of workplace bullying. A study conducted by Inagaki & Eisenberger (2016) found out that social support increases health outcomes, thus, it reduces *'sympathetic nervous system related responses to stress'*. Continuous support coming from loved ones helped the participants to overcome their anxiety and stress as apparent in this significant statement:

"I overcome this predicament through the support of my family and friends. My nurse manager did a great job in resolving our organizational conflicts, thus, she transformed it to conducive working environment for all of us". (Transcript # 13)

The Butterfly Effect: Cessation of Workplace Bullying

Victims of bullying may also lead to constructive development, knowing ones uniqueness, and interpersonal realization leading to one of the cluster themes, *standing tall after the storm*. Felbinger (2008) mentioned that constructing a safe workplace decreases incidence of workplace bullying, thus, having absolute tolerance

cutbacks occurrence of 'aggression and dissention' (Etienne, 2014). Consequently, participants showed self-reliance during the succeeding follow-up interviews. It manifest in the way they utter their words that they are now stronger and wiser to deal diverse situations in life. Participants have all agreed that workplace bullying has changed them for the better. The experience taught them how to maintain their composure at times they were distressed. They learn how to fight and stand for what they believe is right for them.

Moreover, *helping others* is the last cluster themes for this emergent theme. At this point, participants at present are actively participates in initiating campaigns and advocacies to workplace bullying. All of them felt good in sharing their lived experiences that made them the best versions of themselves.

"My experience as a victim of bullying taught me so many lessons in life. It made me stronger and wiser. I am confident that I know my capabilities and myself. I want to impart these lessons to others who are in the same shoes I had before. To fight workplace bullying." (Transcript # 14)

Conclusion

The lived experiences of the participants toward workplace bullying came up with four (4) emergent themes, which depicted their lived experiences. *The target: ideal victim of nurses' bullying* described the nurses commonly bullied in the hospital. *The bully: the art of intimidating and oppressing* depicted the antagonistic character that repeatedly commits atrocious acts to target, bullied nurses. *The face off: confronting dilemmas* portrayed the struggles of the participants to fight their major enemies, themselves. However, through the support of their family, friends, and other support groups, all of the participants managed to conquer their fears, anxiety, stress, and depression. Lastly, *the butterfly effect: cessation of workplace bullying* represented the metamorphoses of the participants into oppressed and weak personas into an enlightened and highly-motivational nurses who are willing to share the lessons they have learned from their lived experiences.

The essence of the study centralizes on educating the nurses not only in the Philippines but also all over the world, in spite of their racial and cultural backgrounds and underpinnings, socio-economic class, individual difference, and perspectives in life, about their human rights, nature of workplace bullying, and how to successfully overcome this phenomenon. Management should commence training and development that builds team organization and camaraderie through team buildings, personality development, and seminars about workplace bullying. Creation of anti-bullying programs and campaigns are highly recommended if workplace-bullying cases do not decline. Finally, mentoring and coaching platforms should exist to nurses to develop their knowledge, skills, and attitude in preparing them for the challenges of tomorrow.

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Learning objectives

Participants will...

1. have a better understanding of hospital bullying and its kinds.
2. have a better appreciation of the negative effects of workplace bullying especially with nurses.
3. be aware of the strategies of bullied nurses in coping, adapting, and adjusting in this kind of phenomenon.
4. Be able to construct ways and measures on how to eradicate workplace bullying specifically in the health care department.
5. demonstrate awareness when does bullying starts and what measures can stop bullying.

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User Evaluation of Availability of Medicines in Nigerian Public Hospitals: Why do Urban Dwellers Purchase Medicines from For-Profit Pharmacies?

Sub-theme: Aggression and/or violence toward staff or service users

Poster

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Keywords: Availability of medicines, Nigeria, Public Health Facilities, for Profit Pharmacies

Abstract

Non-availability of medicines in Nigerian Public Health Facilities (PHFs), which constitute the best option for the common man, undermines the global health reforms to improve access to health for all, especially the chronically ill and poor. Thus, healthcare users, irrespective of purchasing power, buy medicines at exorbitant prices from for-profit pharmacies. We examined user evaluation of medicine availability in public facilities and how this influences their choice of where to buy medicines in three states- Cross River, Enugu and Oyo-of Southern Nigeria. We approached and interviewed 1711 healthcare users, with an interviewer-administered questionnaire, as they visited for-profit pharmacies to purchase medicines. This allowed both buyers who had presented at health facilities (private/public) and those who did not, to be included. Information was collected on why respondents could not buy medicines at the hospitals they attended, their views of medicine availability and whether non-availability influences their choice of for-profit pharmacies and/or self-medication. Mean age of participants was 37.58 ± 14.9 years; 52% were males, 59% were married, 82% earned \geq NGN18,000 (US) per/month, the national minimum wage, and 72% were not enrolled in the National Health Insurance Scheme. Majority (66%) had presented in a hospital, and had prescriptions; of this, 70% were from PHFs. Eighteen percent of all respondents felt that all their medicines were usually available at the PHFs, most were available (29%), some were available (44%) and not always available (10%). Reasons for using for-profit pharmacies included: health workers attitudes (43%), referral by providers (43%); inadequate money to purchase all prescribed drugs (42%) and cumbersome processes for obtaining medicines. Lower availability of medicines has serious implications for healthcare behavior, especially in the context of poverty. It is crucial for government to fulfill its mandate of providing access to care for all by ensuring medicines are available and cheap in all PHFs.

Learning objectives

Participants will...

1. have a better understanding of the reasons why patients seek or buy medicines from pharmacies instead of hospitals.
2. realise that the attitude of health workers contribute to health seeking behaviour of patients.

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Staff Injury and Patient Seclusion Before and After Implementation of a Safety Plan in a Psychiatric Unit

Sub-theme: Aggression and/or violence toward staff or service users

Poster

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Keywords: Violence, Staff Injury, Seclusion, Psychiatric Unit, Health Care, Workplace Safety, Legislation

Abstract

Across time the chronic aggressive behavior of a single patient on a hospital psychiatric unit can threaten the safety and well-being of numbers of patients and staff members. Recently, there is increased concern in society for protecting workers– including healthcare workers – from violence. At the same time, there is increased attention on efforts to reduce the use and duration of physical isolation as a tool for managing aggressive behavior. This case study will compare work-related injury hours for personnel on a hospital psychiatric unit before and after the implementation of a behavioral safety plan for one particularly violent patient. A comparison will also be made of the frequency and duration of seclusion episodes before and after the introduction of the plan. Finally, the frequency of psychotropic medication administered on an as necessary basis will be compared before and after implementation of the behavioral safety plan. Elements of the safety plan and concepts from the research literature will be discussed in the context of the findings. Recommendations will be generated for future research.

Learning objectives

Participants will...

1. be able to appreciate the dilemma, for health service leaders, of protecting employees from violence and promoting restraint reduction for patients.
2. be able to compare injury and seclusion frequency before and after the introduction of a behavioral safety plan for one particularly violent patient.

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Physiological Effects Of Standing Head-Hold Restraint Positions

Sub-theme: Quality safety and risk reduction initiatives

Poster

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Keywords: Restraint, Lung Function, Physiological Effects

Abstract

Restraint in a standing position may require control of the head in order to avoid spitting or biting. This may be particularly relevant whilst moving a restrained person from one location to another.

This was a laboratory study, using 22 young adult volunteers in a university setting. The study measured the effects of four different head-hold positions on lung function, heart and circulation. The subjective experiences of the participants were also recorded. The study compared a standing control position with the restraint positions. Each head-hold position was tested with participants bent forwards at two different angles.

There was little - largely non-significant - physiological difference between the tested head-hold techniques and the standing control position. Leaning the participants forwards during restraint also had little physiological effect. Participants expressed subjective preference for a head-hold technique where they were held at arms length and this was most comfortable in the more upright position.

It was noted during the conduct of the study that holding the participants mouth shut and/or their chin bent down to the chest, was reported as difficult to breathe and uncomfortable. This would be a misapplication of the techniques and should be avoided.

Learning objectives

Participants will...

1. Appreciate that the use of head-holds and forward leaning in order to control biting, spitting or kicking appeared to be safe using the techniques tested in this study.
2. Will learn that holding a restrained person's head at arms length may be less uncomfortable and/or invasive. It may be argued that this is also safer for restraining staff.
3. Appreciate that care should be taken to avoid holding the person's mouth shut and to avoid placing their chin onto their chest.

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Evaluation of the outcomes of criminal proceedings against patients involved in violent incidents within a Mental Health Service

Sub-theme: Aggression and/or violence toward staff or service users

Poster

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Keywords: Inpatient, Mental Health, Prosecution, Assault, Violence

Abstract

The Zero Tolerance approach toward violence across the NHS has been widely publicised as a response to an increase in violence toward hospital staff. However, in mental healthcare, anecdotal evidence suggests that violence is under-reported and to some extent seen as ‘part of the job’. This is partly due to the impression that such reporting frequently yields no tangible consequence, or that the mental illness is exculpatory.

In some mental health trusts, violent incidents are routinely reported to the police and consultant psychiatrists are approached for witness statements as to whether the patient in question is fit to be interviewed, arrested and charged. This project was intended to follow up on such cases in a specific regional NHS Trust involving patients vetted to have the capacity to form criminal intent. The aim was to explore whether any further legal action was taken; and if so, examine the outcome of the legal process followed.

The outcomes confirmed national trends in inpatient violence. There were some discrepancies in the procedures followed by the Criminal Justice Agencies in pursuing cases of inpatient violence as opposed to violent behaviour in the wider community. There was a greater focus on using community resolutions. The outcomes also suggested a higher threshold to prosecution being applied to inpatient violence which effectively undermines the ‘Zero Tolerance’ ethos.

Learning objectives

Participants will...

1. Appreciate that there may be clinically sound reason to pursue criminal prosecution in inpatients involved in violent behaviour.
2. Have a basis to challenge the stigma attached to Mental Illness that a psychiatric condition is always exculpatory
3. Be able to reflect on the inpatient ward as equivalent to the community for those residing or working there and that those subjected to violence should be afforded the same representation in law as individuals in any other community

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Terminally Ill Patients Denied the Right to Die Well

Sub-theme: Aggression and/or violence toward staff or service users

Poster

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Keywords: Euthanasia, corrupt families, ethics, legislation, Cameroon

Abstract

Because there is no law on euthanasia in Cameroon, unscrupulous physicians tend to rob wealthy patients of their wealth by maintaining them (brain dead) on medical gadgets over months or withdrawing treatment prematurely to enable corrupt family members to inherit the deceased's property. Many die of bedsores. Some commit suicide. Others die without wills.

Elsewhere, the laws grant terminally ill patients the right to "aid in dying". This means patients with degenerative diseases or dementia could make advance directives when they still have legal capacity. Otherwise, family members could make such decisions based on what they believe the patient would want, given utmost priority to the patient's wishes and values. With such laws, patients could refuse, limit or end medical treatment and let the disease take its natural course in order to die well. This is not the case in Cameroon.

The constitution of Cameroon, one of the most corrupt countries of the world, does not grant terminally ill patients the right to end of life decisions. A patient's probability to die in dignity or in shame is largely determined by nurses and physicians. Some medical practitioners have taken advantage of the absence of legislation to rob wealthy patients suffering from terminal diseases or dementia of their wealth by maintaining them (brain dead) on medical gadgets for months, charging exorbitant fees. Many are dying of bedsores. Others simply withdraw treatment after receiving bribe from unscrupulous family members who intend to inherit the deceased's property.

Learning objectives

Participants will...

1. learn about cases of malpractice in vulnerable patients.
2. will appreciate the role of care-givers' professional and moral standards in such lawless settings.

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Workplace Violence Against Physicians: A Cross Sectional Study from Different Hospitals of Nepal

Sub-theme: Aggression and/or violence toward staff or service users

Poster

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Keywords: Physicians, Hospitals, Patients, violence

Abstract

The workplace violence in the healthcare setting has been becoming universal global health issue especially in resource-limited settings. Violence against physicians in Nepal is grooming since last decade because of political instability however the issue is unresearched and significantly low documented.

The study was designed I. To evaluate the incidence, frequency and contributing factor to promote the violence against physicians in Kathmandu, ii. To identify the existing law, policy and management modalities to tackle the issue.

A descriptive cross sectional approach was employed. A self-administered questionnaire was used to collect the data on different aspect of workplace violence against physicians in different hospitals of Kathmandu between February 2016 to April 2016. The questionnaires were distributed to 169 physicians of different hospitals of Kathmandu. The in-depth interview was carried out with the policy makers and other regulatory personals to find out the mechanism coped by the regulatory organisation to minimize and control the violence against physicians.

With the respondent rate of 66.27%, male and female respondent rate was 78.57% and 21.42% respectively. The majority of respondent had 1-5 years of experience with the private organisational settings. 69.64%(n=78) of the respondents had experienced at least one form of workplace violence in their professional life. The most common form of violence was verbal abuse, verbal threats unwanted calls and physical assaults, which account 55.35%, 37.5% 28.57% and 16.96% respectively. Physicians working in the evening shift were assaulted more followed by the night and morning shift due to higher flow of patient in evening shift. 56.25% of physician had experienced the violence from patients while 46.42% had experience assault from relatives of patients. Majority of the respondents and in-depth interview had claimed that long waiting hours, poverty, uneducated mass of visitor and in some cases psychiatric patients also make the work place turbulent. Importantly, lack of cooperation and patience between the physicians and visitors during the treatment of the patient had further exaggerated the tension. Use of drugs and alcohols by patients and visitors also affected the working place of hospital to be more violent. Keep silence was the most common mechanism of coping the adverse situation followed by physicians.

The study showed that the physicians are at high risk of incidence of violence in resource limited setting like hospitals in Nepal. The government and management body of the Organisation should adopt the appropriate coping mechanism to address this issue against physicians. The government should formulate dynamic approaches and laws to promote a peaceful environment at hospitals.

Learning objectives

Participants will...

1. learn about the incidence, frequency and contributing factor to promote the violence against physicians in Kathmandu.
2. learn of modalities to tackle the issue based on the existing law, policy and management.

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Persistent workplace violence against health workers in Nigeria

Sub-theme: Aggression and/or violence toward staff or service users

Poster

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Keywords: Workplace violence, Nigeria, Underreporting, Data collection, Lukewarm response, Health workers, Psychological trauma, Service delivery.

Background

Workplace violence in the health-care sector in Nigeria has for too long been tolerated and largely ignored. Workplace violence is everyday reality, but its persistent occurrence in Nigeria health sector trumps concern. However, lukewarm response or no response at all deter health workers from reporting incidents, further obscuring the issue. Adding layer of difficulties to the already existing problem can be blamed on religious beliefs, illiteracy, poverty and insurgency especially in the Northern Nigeria where there is poor reputation for violence on health workers.

Nevertheless, prevalence is not restricted to patient-healthworker dispute but growing dispute among health workers that tends to erode health work ethics and water down the quality of health care service delivery. Violence challenges faced by health workers appears in different forms ranging from physical assault, verbal abuse, bullying, stalking, terrorism, sexual harassment among others. However, In Nigeria these violence incidents on health workers are grossly underreported and data collected on them circumscribed, thereby limiting the magnitude of the problem.

Methodology

In this participatory cross-sectional study in an organized self-reported questionnaire distributed to 215 health personnel in various health centers in Nigeria. Their experience of workplace violence in line of work reported by 205 respondents is as thus:

Results

Most of respondents had experience workplace violence with more than (60%) occurring in the clinic and (18%) occurring outside the clinic but work related. Psychological trauma account for (78%) of all abuses and verbal abuse was the most prevalent of (85%), while sexual harassment account for (5%), terrorism was the least on (0.5%)

Patients and their relations were the main perpetrators of physical assault and threats, religious beliefs and terrorism account for some death of health workers in Nigeria, while senior colleagues were the main workplace bullies.

Conclusion

Enormous threat pose on safety and lives of health workers in Nigeria deserve urgent attention to address high prevalence rate of workplace violence.

Learning objectives

Participants will...

1. appreciate incessant violence against health workers, service users in Nigeria.
2. learn of possible solution to these issues.

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“Stop Bullying” – working towards zero bullying -workplaces in Finnish Health Care: Campaign 2015 by The Union of Health and Social Care Professionals

Sub-theme: Aggression and/or violence toward staff or service users

Poster

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Keywords: Workplace bullying, occupational safety, harassment, psychological violence, violence minimizing cultures, workplace bullying policy

Background and context

Workplace bullying was the second most common cause of the occupational safety and health reasons why the members approached to the trade union in the year of 2014. Tehy—the Union of Health and Social Care Professionals decided to carry out in the year of 2015 “Stop Bullying” – towards Zero Bullying Workplace campaign. Members were given the opportunity to share their experiences about bullying at work. They were asked to write their stories by via e-mail during one month. It was also one evening when members were offered the opportunity to call from the campaign number as anonymous and tell hers experience about bullying at work. After this was held in the Stop Bullying seminar which was attended by 100 participants on-site and 402 people participated in the webinar. Participants were shop stewards, safety representatives, supervisors and workers and they discussed together how to manage workplace bullying. As a result of the campaign a data bank was produced (in Finnish) on Tehy’s website how to manage workplace bullying <http://www.tehy.fi/fi/ajankohtaista/stop-tyopaikkakiusaamiselle>.

Further work will continue with the study of Occupational Health and Safety in Social and Health Care in cooperation with the University of Vaasa.

Tehy is Finland’s largest trade union for professionals in the health and social care sector. There are over 160000 members of whom 93 % are women. Tehy’s professionals include medical dental nurses, dentalhygienists, laboratory technologists, biomedical laboratory scientists, nurses, midwives, x-ray nurses, practical nurses, physiotherapists, mental health nurses, podiatrists among others.

Findings /Summary of the bullying stories

- It was easier to write about own experience that make a call.
- Some of the cases were going on years without anyone taking responsibility to stop it.
- Bullying was diverse (isolating, overloading, ignoring, controlling, harassment, evil speaking).
- It was easier telling the supervisor about bullying than to say it straight to the bully.
- Also bullies hoping for support and assistance, but bullies do not believe that they would get help.
- It was common that the bullied employee is transferred to other duties and the bullying person stayed.
- In only one case of 49 bullying was treated in accordance with the workplace bullying policy.

Learning objectives

Participants will...

1. appreciate that the common training for shop stewards, safety representatives, supervisors and workers could improve the handling of bullying in the workplace.
2. understand that further work, cooperation and the national research is needed in order to understand the diversity of workplace bullying in the health sector in Finland.

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Pathways to sexual homicide

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Sexual homicide, Sexual sadism

Abstract

Since the publication in 1988 of Ressler, Burgess and Douglas' seminal *Sexual Homicide: Patterns and Motives*, there has been a proliferation of studies on sexual murderers and their crimes. Most of these studies have been performed in the United States, Canada, The United Kingdom, and Germany, and have tended to focus on five specific questions: 1) What are the features of sexual murderers' psychosexual development that favour such extremes act of violence? 2) What are sexual murderers' distinctive personality characteristics, and how are these related to the commission of sexual murder? 3) Are all sexual murderers paraphiliacs, and more specifically sadists? 4) Are there a diversity of profiles of sexual murderers, each defined by specific developmental, personality, and motivational characteristics? 5) Is there a biological basis to sexual homicide, either neurological, genetic, or epigenetic? This presentation will discuss the convergent and divergent results produced by different research groups in the countries mentioned above. In addition, avenues of research likely to resolve some of the inconsistencies in the reported results, and to expand our understanding of the diversity of pathways that lead to sexual homicide will be presented. To conclude, we will discuss the strategies developed by the Canadian Correctional Services to prevent sexual homicide against their female staff, in institution, as well as during the follow-up in the community. Those strategies were implemented following the sexual homicides of two female staff in early 2000's.

Learning objectives

Participants will...

1. identify risk factors in sexual murderers.
2. develop knowledge on strategies to prevent sexual homicide against correctional staff.

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Workplace violence: Experience of community midwives in provision of maternal health services in rural Pakistan

Sub-theme: Aggression and/or violence toward staff or service users

Poster

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Keywords: Harassment, community health workers, violence from community

Background

In recent times, increasing attention is being paid to the spectra of workplace violence in the health sector. Although the health sector is predominantly comprised of female employees, workplace violence targeting female service providers has received insufficient attention from authorities and management alike. A qualitative research was conducted in District Attock, Pakistan to identify the challenges faced by community based midwives in the course of service provision. This article explores the predisposing factors associated with workplace violence against community midwives during their training and at workplace. The objective of this work is to raise awareness among program managers and policy makers concerning the problems faced by community midwives.

Methodology

Focus group discussions (FGDs) were conducted with community midwives to explore workplace challenges. Themes identified were: training and field experiences, the support received from family and work environment. The data presented is however a component of this research with focus on workplace violence. The transcripts were read, data was coded and categorized, from which sub-themes and themes were identified.

Results

Analysis of the data indicates that community midwives face different types of violence during training and field work, including verbal abused from co-workers. As young and new health providers, midwives were forced to endure the hostile attitudes of community members. They faced harassment from men in the communities where they worked. The LHV's and traditional birth attendants were uncooperative with them and appeared to be resentful of their professional abilities, characterizing them as professionally incompetent.

Conclusion

The available data suggests that workplace violence among community midwives is a significant problem which demands the attention of managers and policy makers. The data indicates that young women who are inexperienced, unmarried and have odd working hours, are the victims of violence. Strategies are needed to prevent workplace violence through appropriate legislative means and redressal mechanisms. There is a need to impart training to community midwives in order for them to effectively cope with such situations.

Learning objectives

Participants will...

1. be able to appreciate the extent of violence community health workers are exposed to in developing countries.
2. be able to understand the circumstances leading to vulnerability of the community based health workers in developing countries.

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Can aggression be prevented? Inpatient psychiatric nurses' experiences

Sub-theme: Aggression and/or violence toward staff or service users

Poster

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Keywords: Aggression, prevention, inpatient psychiatric unit

Background and context

Patients admitted to inpatient psychiatric units are increasingly more acute with greater potential for aggression which creates significant risk for the individual patient as well as staff. Previous research has identified stages of aggression that suggest opportunities to intervene to deescalate the aggression and prevent injury to the patient and staff. Yet, little is known how psychiatric nurses identify and intervene to prevent a patient from escalating to aggression. This study's aim was to describe and understand the experiences of psychiatric nurses in preventing aggression.

Methodology

In-depth unstructured interviews were conducted with 10 expert inpatient psychiatric nurses who were asked about their experiences of preventing patient aggression that reduced the need for restraints or seclusion. A phenomenological methodology was used to uncover the themes in the participants' stories.

Findings

Stories were vivid in the participants' mind, even though several were of situations that occurred decades before the interview. One main theme and six sub-themes emerged. The findings were understood within the overarching theme of persistent efforts to maintain a positive and sustained connection with the patient, even when there was danger present. Their interventions to prevent dangerous aggression were effective as long as the patient would remain connected with them. As soon as that connection was broken there was no hope to avoid seclusion or restraint to prevent harm to self or others.

Sub-themes included: 1) an unconditional respect for the patient while balancing patient autonomy and staff member's power; 2) the importance of hearing the story in the patient's voice; 3) continually organizing and interpreting information; 4) fluidity of types of interventions used and modification of interventions; 5) uncertainty about the outcome; and 6) reflection on the situations successes and failures in preventing aggression, seclusion and restraint to inform future practice.

Future directions

This study identifies potential directions for practice and research. The results highlight the importance of continually assessing patients for aggression precursors, and using knowledge of these precursors to intervene to maintain connection with the patient. Several of the identified themes can be used to develop an educational intervention that can assist psychiatric nurses in early detection of aggression precursors, apply strategies to maintain connection with the patient, and how to modify the interventions. Future research could test the effectiveness of the educational program in reducing rates of aggression and associated injury outcomes.

Learning objectives

Participants will...

1. identify 3 interventions nurses used to prevent an escalation of an ongoing episode of patient aggression.
2. critique the identified suggestions for future directions in research and practice.

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Discrimination Experiences in Health Care against Lesbian, Gay, Bisexual, and Transgender (LGBT) People

Sub-theme: Aggression and/or violence toward staff or service users

Poster

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Keywords: Health care discrimination, LGBT, attitudes of healthcare professionals, stigma, homophobia, transphobia

Background and context

Although significant changes have occurred in the social sphere starting of the gay and lesbian movement in the US and Western Europe since 1970s and homosexuality was removed from the DSM classification in 1973, negative attitudes of heterosexuals against these people is decreased but still continue (Johnson *et al.* 2005). LGBT individuals are exposed to negative attitudes in many areas of life as a result of being disapproved of their sexual orientation by cultural and social norms (Göregenli 2004). Consequences of negative stereotypes and attitudes related to discriminatory behaviours to LGBT individuals are fear, hate, verbal and / or physical violence and threats (Sakallý-Uđurlu ve Uđurlu 2004). The link between violence and the discrimination based on negative attitudes towards LGBT individuals is clear. These negative attitudes and beliefs can be existed in health care services as in many areas of society (Polimeni ve ark. 2000, Herdt ve van der Meer 2003, Göregenli 2004; Sakallý- Uđurlu ve Uđurlu 2004). LGBT individuals need for health care services at least as much as general population because of the risk of sexually transmitted diseases and mental health concerns. Researches show that these individuals are experienced inequality in health care services. The reason of not use health care services is thought to be stres, stigma, homophobia and a lack of social support (McNair *et al.* 2001). It was determined that LGBT individuals are not satisfied with the received health care service, less frequently help-seeking behaviours from health care staff than heterosexuals, less often benefit from health care services and have negative experiences in communication with health care professionals (Diamant ve ark. 2000, Bernhard 2001, Stein ve Bonuck 2001, Yen ve ark. 2007, White ve Dull 1998). Furthermore, it is observed that these individuals are less benefited from preventive health services due to fear of being stigmatized (Cochran ve ark. 2001).

Within this context, the purpose of the study is to examine systematically the discrimination experiences of LGBT people in health care. The main question of “what are the experiences of discrimination of LGBT people in health care (whether or not, types, causes / risk factors, results)?” will be sought an answer.

Methodology

This study has been conducting through systematic review of the databases including Google Scholar, Pubmed, Cochrane Library, ScienceDirect. In addition, the reference lists of selected publications and manual search from relevant journals are also reviewed. Relevant articles from past (without date restriction) to 2016 were retrospectively will be extracted without date restriction. The keywords are “health care discrimination”, “LGBT”, “attitudes of healthcare professionals”, “stigma”, “homophobia”, “transphobia”.

Inclusion Criteria for Systematic Review:

1. The full text of research articles to be accessible
2. Peer reviewed articles in English language
3. Original, quantitative and qualitative research

Findings

Data extraction is still ongoing in detailed style by principal authors. Description of studies and the key findings will be presented.

Implications for practice, research, education & training, organisation / management, policy and guidance

This systematic review will be able to expand the knowledge about violence in health care; negative attitudes grounded in health care services to LGBT people will be highlighted. Thus, health care staff' predispositions of being aggressor knowingly or unknowingly will be analyzed and new motivations for future researche will be encouraged.

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Learning objectives

Participants will...

1. Become aware of present conditions related to discrimination behaviours to LGBT people in health care services.
2. Learn of negative effects of discrimination against LGBT people in health care services.

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Towards a Latin-American Observatory of workplace violence against Spanish and Colombian healthcare professionals

Sub-theme: Aggression and/or violence toward staff or service users

Poster

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Keywords: Latin American observatory, third party violence, health sector

Background and context

In 2006, as part of a draft comprehensive research on psychosocial risks at work of health professionals, two members of this team created and launched the www.violenciaocupacional.cat, a computerized system for collecting information on third party violence against healthcare workers. With the support of scientific and professional institutions, the project pursued four main objectives: (1) developing a specific device of online and ontime collecting and processing information on violent incidents; (2) providing a constantly updated epidemiological map on who attacked whom, where, when, how, why, and with what consequences; (3) generating applicable preventive suggestions to avoid or minimize such violence; (4) showing the practical synergies generated by the close collaboration between hospital and academic systems.

Methodology

A network of 65 health institutions Catalan voluntarily participating in the project, delegated to one person per center notification of all cases occurred in it. In this context, between 2007 and 2016, they were registered in the database of the website more than 7,000 violent incidents.

Findings

In most incidents, verbal violence was involved, in a third also physical and occasionally other form of symbolic and economic violence. Men and women shared similar risk of being attacked, but men appeared more frequently as aggressors. Risk factors of occurrence included problems on interpersonal relationship, information management, of profile characteristics of the aggressor (on pathology, psychological decompensation, state of frustration for treatment, strategic behavior, etc.) and the victims.

Projects and Prospective

Locally, the objectives were achieved. Therefore, in 2016, it was created in Spain a scientific collaboration agreement between Catalan and a Valencian group, in order to develop the project also in this community. At the same time, the internationalization of the project is sought through the creation of a basis of a Latin American Observatory on workplace violence. This implies expanding cooperation between the Spanish group and various Colombian universities sited in Barranquilla, Cartagena and Manizales, as a first step towards extending it to other Colombian regions and some other Latin American states from which, some colleagues and institutions have expressed their interest in participating in the project. In the present and in general, Latin American countries recognize the need and urgency to develop the scientific research on third place violence against healthcare workers and to transcend the strict journalistic point of view in treatment of information on this problem, who remains relatively hidden, invisible and perhaps overshadowed by other forms of violence socially more visible in those countries.

Learning objectives

Participants will...

1. learn of a model for mapping the results of ten years of a Catalan observatory on third party violence against healthcare workers.
2. learn of preliminary evidence and results of the Latin American Observatory on workplace violence.

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Workplace violence among healthcare workers in Gondar city health facilities in North West Ethiopia

Sub-theme: Aggression and/or violence toward staff or service users

Poster

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Keywords: Health facilities, health care workers, workplace violence, Gondar

Introduction

Workplace violence is the intentional use of power, threatened or actual, against another person or against a group, in work-related circumstances, that either results in or has a high degree of likelihood of resulting in injury, death, psychological harm, mal development, or deprivation. It has become an alarming phenomenon worldwide and it is one of the largest public health problems.

Objective

To assess magnitude and predictors of workplace violence among healthcare workers in health facilities of Gondar city.

Method

Institutional based cross sectional study design was employed to conduct this study. The study conducted in Gondar town from February 21 to march 21, 2016 G.C. Five hundred fifty three health care workers selected from health facilities of Gondar City administration.

A stratified sampling technique was used for selecting the study units. Data was collected by structured self administered questionnaire which is adapted to fit with this research objective from ILO/ICN/WHO/PSI after it is pretested prepared in Amharic.

The data was coded and entered in to EPI info version 7 and exported to SPSS version 20 software for analysis. The degree of association between dependant & independent variables was assessed using odds ratios within 95% confidence interval and p-value ≤ 0.05 .

Results and discussion

The prevalence of workplace violence was found to be 58.2% with in which verbal abuse 282 (53.1%) followed by physical attack 117 (22.0%) and 38 (7.2%) sexual harassment. Working at emergency departments, working at shifts ,short experiences ,being nurse or midwife were positively associated with workplace violence. The main sources of violence are visitors/patient relatives.

Conclusion and recommendations

Workplace violence is major public health problem across health facilities and the ministry of health should incorporate interventions in its different health and safety initiatives.

Learning objectives

Participants will...

1. learn about the prevalence of violence towards healthcare workers in Ethiopia.
2. be able to differentiate socio economic factors that that determine which health care professional is more exposed in health care industry.

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Perceptions of Role and Occupational Risk of Correctional Nurses

Sub-theme: Aggression and/or violence toward staff or service users

Poster

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Keywords: Correctional registered nurses, occupational exposures, workplace violence, verbal harassment

Abstract

Correctional nursing exposes registered nurses (RNs) to unique occupational health hazards, including increased risk of workplace violence. The percentage of male RNs in the US has substantially increased, reaching 10% of the total nursing workforce in 2009; it is expected to reach 20% by 2020. In Connecticut correctional setting 29% of RNs are male. Although there is a higher proportion of male RNs in corrections, the risks for these nurses compared to nurses working in other healthcare sectors have never been examined. Gender-related risk factors and role expectations may influence occupational exposures and health outcomes differently.

With the increase in male RNs in nursing it is important to characterize and understand occupational exposures, health behaviors and outcomes of male and female RNs, specifically in corrections. **Methods:** The research describes and compares occupational exposures, health behaviors and outcomes of males and females in the correctional nursing workforce. This study describes the perceived differences in gender role expectations and exposure to occupational health hazards, including workplace violence using semi-structured key informant interviews with 16 RNs working from different shifts and units. Interviews lasted between 0.5 to 1.5 hours. All interviews were digitally-recorded and professionally transcribed.

Participants received compensation in the form of gift cards. Researchers reviewed the first six transcripts to sort the discussion topics into categories using guided thematic analysis. A "start list" of themes was created. Data analyzed used the constant comparative method to identify recurrent themes until theoretical saturation is achieved.

The codes and quotes were discussed to resolve discrepancies through interpretive discussions, consensus building, and refinement of code definitions as needed. **Findings:** Guided thematic analysis identified the following themes: Reason for being a correctional nurse; scope of work as a correctional nurse; occupational exposures (physical assaults; verbal harassment; co-worker conflict; bloodborne pathogens; and stress); coping with verbal harassment; perception of safety; prevention and management of occupational risks; public perception and image of correctional nurses; and perception of males nurses in corrections.

Other emerging themes involved: dealing with the inmate population, and retention of correctional nurses (staffing, workload, training, pay, sense of belonging). **Implications:** The shared lived experience of correctional RNs, through their perceptions of role and occupational risks will help identify interventions to reduce gender-based occupational health risks and promote the health and well-being of correctional nurses that may be distinct from nurses in other healthcare sections.

Learning objectives

Participants will...

1. be able to describe the perception of role as Correctional Registered Nurses.
2. be able to compare the pattern of occupational health exposures between male and female correctional RNs, including workplace violence.

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Does the feeling of anger always lead to aggression?

Sub-theme: Aggression and/or violence toward staff or service users

Poster

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Keywords: Aggression, anger, emotion regulation, anger regulation strategies

Background

Studies indicate that people's feelings of anger are strongly related to aggressive behaviour. However, state of the art studies in the field of emotion regulation show that aggression can be treated only as a subtype of one out of the seven anger regulation strategies. In the literature, anger regulation strategies are divided into two types: functional and dysfunctional. The functional anger regulation strategies are those that help individuals reduce the level of discomfort and arousal. The dysfunctional anger regulation strategies do not alleviate the feelings of anger. Four types of functional strategies can be distinguished: distraction, downplaying, humour and feedback, in addition to three types of dysfunctional strategies: venting (which includes aggressive behaviour), rumination and submission. According to research, the use of functional anger regulation strategies is related to physical and mental health. Anger regulation is also vital for interpersonal relationships and functioning in the workplace.

Methodology

Healthy adults (N=252, aged: 18-62) participated in the survey. People were asked to fulfil Anger-Related Reactions and Goals Inventory.

Findings

The vast majority of people do not have a dominant strategy of regulating anger. Each person has a habit of using more than one anger regulation strategy. Apart from displaying aggressive behaviour, individuals are able to react differently to anger triggers.

Implications

By adapting functional anger regulation strategies, individuals would be able to decrease their aggression in social contexts. People may establish new habits e.g. by participating in workshops organized by employers or non-governmental organizations.

Learning objectives

Participants will...

1. appreciate that anger do not necessarily to lead to aggression.
2. learn of different anger regulation strategies that persons habitually use.

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Antecedents and precipitants of patient-related violence in the emergency department: Results from The Australian VENT Study

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: Emergency department, triage, nurse, violence, patient-related

Background & context

Workplace violence is one of the most significant and hazardous issues faced by nurses globally. It is a potentially life-threatening and life-affecting workplace hazard often downplayed as just “part of the job” for nurses.

The emergency department is one of the highest risk areas, with patients identified as the main source of this violence. While studies on the topic have previously been conducted in Australia, no national study had been undertaken. Consequently this presented the opportunity to conduct a national survey of emergency department nurses.

Methodology

A cross-sectional design was used and data were collected using a purpose developed survey tool. Surveys were distributed to all members of the College of Emergency Nurses’ Australasia (CENA) in 2010 and 537 eligible responses were received (RR = 51%).

Findings

Patient-related violence was reported by the 87% of emergency nurses surveyed, and triage nurses were identified as being at highest risk of such violence. A number of precipitants and antecedents were found to be significant and are unavoidable in the working lives of emergency department nurses. These included the nursing activity of triaging, long waiting times and delays and presentations of alcohol intoxication, substance misuse and mental health issues. Statistical analysis was used to quantify the risk posed by these factors.

The results showed that these factors increased the risk of violence by up to five-times and emergency nurses can be exposed to multiple factors, with a corresponding increase in risk.

Implications

This national Australian study confirms that emergency department nurses are working in a high-risk environment. The risk factors for patient-related violence identified were multi-factorial and include nurse-related, patient-related and factors specific to the emergency department itself. These factors can combine or overlap to create a lethal cocktail where violence is inevitable. The requirements under Work Health and Safety legislation for a safe workplace for all staff mean that the management of such issues must be a priority and cannot continue to be ignored.

Learning objectives

Participants will...

1. gain an understanding of patient-related violence faced by emergency department nurses in Australia.
2. be able to identify the highest risk factors for violence and understand further the potential for these factors to overlap and increase the risk to nurses correspondingly.

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Workplace Violence faced by Doctors in a Rural tertiary hospital of Central India: Pattern & Intervention

Sub-theme: Aggression and/or violence toward staff or service users

Paper

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Keywords: violence, doctors, pattern, Intervention

Background & context

India is the second most populous country in the world with 72% of its population having a rural background. The health facilities are relatively inadequate for the population at large & more so in the rural areas. Our hospital is a 1500 bed general hospital in central India catering to the needs of the surrounding rural population. Attempts have been made to make the services cost-effective and yet, not compromising on the quality of services. Lack of awareness, poor financial condition, low literacy rate, prevalence of superstitions & the tremendous belief in faith healers causes the service users to be preoccupied on many occasions with the outcome of treatment & its need for cure. They tend to suspect the doctors intentions in this regard. Hence, on many occasions hospital stay seems to be prolonged, chances are that relative & friends may become violent. A poor outcome after treatment also triggers violence. The treating Physician or the surgeon is subjected to violence ranging from verbal abuse to physical assault. Impatience on the part of the patients & their relatives also result in such violence. Hence, study to assess the pattern of violence faced by the doctors in our setup. We would like to assess the data & see what is the most common form of violence used & how could we minimise it so that the doctors may be able to work in a fearless environment & provide the best of healthcare services to its service users. We would see if there is more violence towards a particular gender of doctors of a particular speciality. In Psychiatry & Emergency medicine departments, violence is generally assumed to be more than others, hence this study. Finally we would like to assess as to how we can minimise all such violence & make the work place environment safe & violence free.

Methodology

- Study Site: Department of Psychiatry, Acharya Vinoba Bhave Rural Hospital & Jawaharlal Nehru Medical College
- Type of study: Cross sectional
- Subjects: Doctors involved inpatient care from various departments.
- Type of sampling: Purposive
- Total number of subjects: 60
- Duration of study: Data was collected between 1st January 2016 to 20th February 2016.
- Instrument Used: Workplace Violence in Health Sector country case study –Questionnaire.

Inclusion criteria:

1. Subjects consenting to be a part of the study & willing to provide unbiased view via the answers in each section of questionnaire.
2. Subjects with a minimum of 1 year of experience in the hospital setup.

Exclusion criteria:

1. Subjects with less than 1 year of experience in the setup.
2. Subjects not willing to be a part of study.

Findings

Currently, data has been collected from 60 doctors involved in the hospital for more than 1 year. The statistical analysis is underway & we expect to be ready with the results & their inferences by the 10th of March 2016. However, it seems from the data that the subjects have mostly faced psychological violence & less of physical violence, the details of which will be made available after complete statistical analysis.

Learning objectives

From the above study, we will be able conclude the following.

1. Prevalence of aggression against doctors in our hospital setup.
2. Common types of aggression encountered on day to day basis.
3. Most violent forms of aggression encountered.
4. Reason for such violence at the setup.
5. Violence & Gender bias.
6. Strategies that need to be adopted to address all such issues and minimise such occurrences.

All such studies can help identify the reason for health care violence in the developing countries & come to a consensus as to how the management protocol should be standardised for a better doctor patient relationship & improvement of communication skills so as to reduce all such unpleasant happenings in hospitals & most importantly, make the health care atmosphere pleasant for the service provider as well as the service users so that healing does not hurt.

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Comorbidity in cases with violence episodes

Sub-theme: Aggression and/or violence toward staff or service users

Poster

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Keywords: aggression, psychiatric comorbidity

Abstract

Psychiatrists experience risks of violence in clinical settings or emergencies .

Relationship between presentations at referral and diagnosis is seen in following 4 cases where aggression was reported.

Cases of - ASD with Borderline IQ and OCD symptoms, obesity with violent episodes, Periictal (post cluster attack) aggression in patient with past history of alcohol abuse, Cannabis dependence with acute psychosis and related violence with past history of conduct disorder, TBM / miliary TB on irregular ATT with history of multi substance abuse and disruptive behaviour will be described.

Comorbidity of above situations with violence makes it a challenging situation for doctors, nursing staff and relatives.

Guidance for handling such emergency situations and minimizing episodes of aggression is required.

Learning objectives

Association of brain related and psychiatric disorders with aggression is known. Awareness and assessment of situations leading to recognizing and responding appropriately to aggression leads to minimizing risks and stress involved and addresses better patient care in tertiary hospitals with multispeciality facilities.

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Incivility as Experienced in Nursing Academia: A Focus on Faculty and Students

Sub-theme: Aggression and/or violence toward staff or service users

Poster

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Keywords: Incivility, nursing, horizontal violence, vertical violence, burnout, nursing students

Background

Nursing students are the future of nursing. Nursing faculty play a vital role in the development of future nurses. Both faculty and student nurses have been documented to be recipients and initiators of Incivility. Incivility is prevalent among both groups, including practicing nurses, who interact with faculty and students. Incivility has major impacts on nurses' physical and mental health, as well as years of practice in nursing.

Purpose

The purpose of this poster is to describe published data about types and rates of incivility in nursing education as experienced by and from faculty and students.

Methodology

A literature review will be conducted using PubMed and CINAHL. Search terms will be: nursing, faculty, nursing student, Incivility, horizontal violence, and vertical violence. Reference lists from each article will also be reviewed. Inclusion data will be: published within the last 10 years (2005-2016), published in a peer-review journal, statistical data present (if quantitative). Exclusion data will be: articles irrelevant to the topic, data with no statistical results (if applicable), data about Incivility among non-academic nurses that has no connection to faculty and/or students. Data will be extracted and synthesized.

Results

Results will be shared pending completion of this systematic review. An evidence table will be provided.

Discussion

Incivility is a major problem in nursing that contributes to burnout and loss of nurses from our profession. Incivility occurs among and between faculty, students, and practicing nurses in clinical settings.

Implications

Given a world-wide nursing shortage with soon-to-be retiring Baby Boomer nurses, the profession of nursing cannot afford to lose new nurses because of incivility.

Conclusion

Research indicates the negative emotional, physical, and financial cost of Incivility is high. Effective interventions are needed to decrease incivility occurrences among nursing faculty, students, and practicing nurses.

Learning objectives

Participants will...

1. be able to identify types of incivility experienced by and to nursing faculty and students.
2. be able to review evidence-based table with current literature regarding incivility that impacts nursing students in the health care work environment.

3. be able to assemble synthesized data to develop conclusions regarding incivility as it impacts the future of nursing.

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Chapter 4 – The impact of aggression and/or violence

This chapter encompasses presentations on the following sub-themes of the conference:

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

Minimising the physiological and psychological risks of prone restraint

Sub-theme: Physical/Injury impacts of aggression/violence

Paper

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Keywords: Acute mental health, aggression, anxiety, manual restraint

Background

Restraint related deaths are multi-factorial with prone restraint remaining a concern due to the physiological and psychological risks, with much of the discussion limited to ventilatory compromise imposed by this restraint position (i.e. positional asphyxia). However, the limited evidence available suggests a focus on body position alone is too simplistic, and there is a greater need to help health and social care professionals to understand the wider aspects of restraint-related deaths.

Context

Rather than prohibit prone restraint, recent NICE guidelines (2015) recognise that prone should be avoided with the supine restraint position used as the preferred floor restraint position in the emergency management of acute behavioral disturbance and violence. If prone cannot be avoided during an emergency, the guidelines suggest that careful consideration should be given to the individual's dignity, safety and welfare suggesting the position is time-limited with a focus on reducing the physiological and psychological risk factors that are likely to lead to adverse outcomes.

Methodology

In two separate studies, participants were ran to near maximal exertion before being held in two prone restraint positions: The Supported Prone Position (SPP) and the Unsupported Prone Position (USPP) with the hypothesis that the SPP will reduce the physiological and psychological impact on emergency prone restraint.

Findings

Both studies demonstrate that the SPP significantly reduces the physiological and psychological impact on the individuals, thereby mitigating some of the concerns around prone restraint.

Implications

The authors argue that in an emergency where unplanned prone restraint occurs the SPP is a safer emergency prone position when compared to the USPP. Those organisations using an USPP should consider removing this specific intervention in favour of the SPP as a way of mitigating adverse restraint related outcomes.

Learning objectives

Participants will be able to..

1. Identify the range of factors associated with restraint-related adverse outcomes.
2. Identify the difference between a Supported and Unsupported prone position and why these differ in their physiological and psychological impact.

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The Aggression Observation Short Form identified episodes not reported on The Staff Observation Aggression Scale-Revised

Sub-theme: Physical/Injury impacts of aggression/violence

Paper

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Keywords: Aggression, Violence, Outcome measure, Timesaving, Quantification

Introduction

In this presentation the result from our study will be presented.

Objective

To evaluate the underreporting of violence and aggression on the Staff Observation Aggression scale-Revised (SOAS-R) when compared to a simpler assessment: the Aggression Observation Short-Form (AOS).

Method

During a period of 1 year, 2 open and 2 closed wards gathered data on both the SOAS-R and the AOS for all of their patients. The 22-item SOAS-R is to be filled out after each violent episode. The 3-item AOS is to be filled out during each shift and should also record the absence of violence.

Results

The SOAS-R registered 703 incidents and the AOS registered 1,281 incidents. The agreement between the SOAS-R and the AOS was good ($\kappa = 0.65$, 95% CI=0.62-0.67). Among the 1,281 AOS episodes, 51% were also registered on the SOAS-R. For the 176 AOS episodes with harm, 42% were also registered on the SOAS-R. We found 44% missing registrations on the AOS, primarily for open wards and for patients with short admission lengths.

Conclusion

Standard instruments such as the SOAS-R underreport aggressive episodes by 45% or more. Underreporting can be reduced by introducing shorter instruments, but it cannot be completely eliminated.

Learning objectives

Participants will...

1. appreciate that less time-consuming instruments will limit underreporting of aggressive episodes.
2. appreciate that if quantification of the rate of aggression is the goal, less time-consuming instruments is the way to do it.
3. learn that severe aggressive episodes tend not to be reported on the SOAS-R.

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The Relationship Between Adverse Social Behaviors and Health Problems in the Korean Healthcare Sector

Sub-theme: Physical/Injury impacts of aggression/violence

Poster

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Keywords: Adverse social behaviors, Health problems, Korean working conditions survey

Objectives

This research was conducted with the goal of determining the correlation between adverse social behaviors and health problems in the Korean healthcare sector.

Methods

Data were derived from the third Korean Working Conditions Survey (KWCS), conducted in 2011 by the Korea Occupational Safety and Health Agency. The survey population was a representative sample of the working population, ages 15 ~ 65.

We selected healthcare sector workers, resulting in a final sample size of 2,041 respondents. Adverse social behaviors were investigated to see whether individuals had suffered verbal abuse, unwanted sexual attention, or threats and humiliating behavior during the previous month.

Among the respondents (n=2,041), those who answered 'yes' to any of three questions were used as the case group. Those who answered 'no' to all three questions were used as the reference group.

Health problems were categorized as backache, headache, abdominal pain, muscular pain, stress, fatigue, insomnia, anxiety or depression. Each problem was analyzed for its relationship to adverse social behaviors through logistic regression analysis.

Results

Among the 2,041 workers, 4.9% reported having experienced verbal abuse. Humiliating behavior occurred less frequently, with 1.5 % of workers reporting having been humiliated or threatened in the previous month. Unwanted sexual attention was the least prevalent, being reported by just 0.8% workers. For the case group, adverse social behaviors appeared to be linked more closely backache (OR; 2.35%, CI; 1.45 ~ 3.89), muscular pains in shoulders, neck and/or upper limbs (OR; 2.50, 95% CI; 1.68 ~ 3.83), muscular pains in lower limbs (OR; 3.86, 95% CI; 2.54 ~ 5.87), headache (OR; 3.70, 95% CI; 2.40 ~ 5.70), cardiovascular diseases (OR; 10.20, 95% CI; 1.86 ~ 55.99), depression or anxiety (OR; 7.50, 95% CI; 2.50 ~ 22.51), overall fatigue (OR; 2.99, 95% CI; 1.95 ~ 4.58) compared to the reference group.

Conclusion

The study showed that the experience of adverse social behaviors is correlated with work-related health problems. Additional research should investigate ways to reduce adverse social behaviors.

Learning objectives

Participants will...

1. have an understanding of the prevalence of adverse social behaviors in the Korean healthcare sector.
2. be aware of relationship between experience of adverse social behaviors and health problems.

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Depressive disorders as a result of military aggression in persons from Anti Terrorism Operation Territory

Sub-theme: Emotional/Psychological impacts of aggression/violence

Poster

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Keywords: Anti Terrorism Operation Territory, military aggression, depression, PTSD

Background

Modern life of Ukrainians is filled with exciting, disturbing, and staggering events. As a result of contemporary military aggression in territory of Ukraine the number of persons who were transferred from the Anti Terrorism Operation Territory (ATOT) in the east of Ukraine with various mental disorders has grown exponentially. Their clinical picture of this impairment presented by a wide range of symptoms across the depressive spectrum with different structure and severity.

Study aim

The purpose of our research was to study depressive disorders in civilians who were transferred from the ATOT. 60 persons were involved (30 men and 30 women).

Materials

The patients were examined with: clinical methods, psycho-diagnostic methods (Hamilton Depression Rating Scale (HDRS), State-Trait Anxiety Inventory, Quality of Life Test (Mezzich I., Cohen N., Ruiperez M., Lin I., and Yoon G., 1999). The data were analyzed by descriptive statistical methods.

Results

The results that we got demonstrated that the most frequent groups of complaints were Fatigue, tiredness, asthenia, weakness; Irritability, outbursts of anger; Inability to control emotional reactions; Anxiety and reduced mood level. Flashbacks, pavor nocturnal nightmares were observed in 33.3 % of patients, but the total amount of patients with sleep disorders was 83.3 %. The main patho-psychological syndromes in civilians were astheno-anxiety (46.7 %), astheno-depressive (40.0 %), astheno-phobic (10.0 %) and astheno-hypochondriacal (3.3 %).

The State-Trait Anxiety Inventory showed that indices of reactive anxiety average score – 38.7) were higher than the indices of a personal anxiety (average score 34.6). Patients with moderate level of anxiety predominated. An average score on the HDRS was 22.3. 50 % of all persons had mild level of depression. 40.0 % - moderate and 10% severe level of depression.

The Quality of Life Test data showed that the lowest scores from our respondents was on the sub-scales psychological condition, psycho-emotional support; social support and general quality of life (results for these scales were less than 5.0 points).

Complex estimation of clinical and patho-psychological data established that in a majority of persons who were transferred from the ATOT showed symptoms of mental disorder. IN our sample we found the following: F43.1 PTSD: n = 10 (16.7%); F 43.2 Adjustment disorder: n = 8 (13.3%); F41.1 Generalized anxiety disorder: n = 14 (23.3%); F 41.2: Mixed anxiety and depressive disorder: n = 12 (20%); Z65.5: Exposure to disaster, war and other hostilities: n = 16 (26.7%).

A multimodal based system of psychotherapeutic correction of neurotic, stress-related disorders in civilians who were transferred from ATOT was developed. This system consists of 3 stages (adaptation, therapeutical, support) and includes rational, hypno-suggestive therapy, Cognitive Behavioural Therapy and autogenic-

training. The proposed psychotherapeutic treatment improved the quality of life and social functioning of the patients. By the end of the final stage of the therapy our patients were involved in self-regulated groups of psychological support.

Learning objectives

Participants will...

1. appreciate the impact that military conflict can have on mental health.
2. learn which type of psycho-therapeutic treatment helps to alleviate adverse mental health symptoms.

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A Comparison of the Emotional Impact and Support Systems Used Following Workplace Aggression

Sub-theme: Emotional/Psychological impacts of aggression/violence

Paper

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Keywords: Emergency department; nursing; verbal abuse; threats; assaults; mental health

Background and context

Workplace aggression (verbal abuse, threats of aggression, and physical assaults) committed by patients and visitors against emergency department (ED) workers is highly prevalent. The specific impact of this aggression is unknown for these workers. The purpose of this study is to describe the emotional impact of workplace violence, compare the emotional impact of workplace aggression by category of aggression, and identify the primary support mechanisms used by ED workers who experience workplace aggression.

Methods

A cross-sectional survey design was used with 280 ED workers employed in six emergency departments in the Midwest United States. Respondents completed the "Survey of Violence Experienced by Staff." Respondents reporting an incident of aggression within the last 30 days described the emotional impact for the worst incident (ranging from 0 to 100) and the support mechanisms used after the incident. Data were analyzed using frequencies, means, and Chi-square statistic.

Findings

Most respondents (n=234, 83.6%) experienced verbal abuse. The mean emotional impact for their verbal abuse was 29.8. About half (n=149, 53.8%) of respondents experienced a threat of aggression. The mean emotional impact for the threats of aggression was 30.5. Over half (n=148, 53.2%) of respondents were physically assaulted. The mean emotional impact for being assaulted was 31.8. There was no significant difference between the three distributions for emotional impact, $p=0.064$. Primary support mechanisms were colleagues and family members. Forty respondents sought no support after workplace aggression.

Implications

Interventions to mitigate the emotional impact of workplace aggression need to be effective for all its various forms, including verbal abuse. Coworkers seem to be a vital source of emotional support for victimized emergency department employees in the United States. These findings debunk the myth that verbal abuse is not emotionally problematic for emergency department employees. In addition, they reflect the need for colleagues to be formally trained in mitigating the emotional injuries caused by aggression committed by patients and visitors.

Learning objectives

Participants will...

1. be able to state the incidence of workplace aggression committed by patients and visitors and against emergency department workers in the Midwest United States.
2. be able to compare the emotional impact of workplace aggression by aggression categories.
3. be able to discuss intervention strategies to mitigate the negative emotional impact of workplace aggression.

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Art therapy in the system of rehabilitation of domestic violence victims in modern conditions

Sub-theme: Emotional/Psychological impacts of aggression/violence

Poster

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Keywords: Art therapy, domestic violence victims, psychopathological and psycho-diagnostic examination, asthenia, anxiety and depression, phobic, vegetative (autonomic), dyssomnic, level of anxiety, the level of depression, anhedonia level, self-confidence increased, asthenic-phobic symptoms

Abstract

In recent years, the problem of providing assistance to domestic violence victims has become a focus of attention of all sectors of the Ukraine population, government agencies, the media and many public organizations.

The purpose of this research is to study the development and approbation of modern approaches for the rehabilitation of domestic violence victims.

In order to achieve this goal, we carried out complex clinical, psychopathological and psycho-diagnostic examination (Luscher's test, Rozensveig's test, SAN-scale, Gamelton's scale, Taylor's anxiety scale) on the base of Kharkiv department of the Ukrainian Fund of violence victims. Forty five victims of domestic violence (29 women and 16 men) aged 18 - 55 years diagnosed with a reaction to severe stress and frustration adaptation (F43) participated in this research.

During our research we identified clinical features of adaptation disorders in the victims of violence. This syndromic structure is characterized by a combination of asthenia ($76 \pm 0,5\%$), anxiety and depression ($65 \pm 0,5\%$), phobic ($50 \pm 0,5\%$), vegetative (autonomic) ($55 \pm 0,5\%$) and dyssomnic ($80 \pm 0,5\%$) disorders.

We have developed approaches to art therapy in the treatment the victims of violence with adjustment disorder. Art therapy included the usage of visual tools, stories, tools of musical and dancing expression as well as techniques of drawing. Art-therapy was conducted in the form of closed group sessions twice a week with a duration of 1.5 hours giving rise to a total of 15-20 lessons. The main tasks of art therapy were the following: sensory stimulation; acting out the feelings, experience of positive emotions associated with creative activity and its results; support and development of communication skills and psychological integration of the patients.

The psychotherapeutic activities conducted helped to reduce the level of anxiety in 70% of patients, the level of depression in 65%, anhedonia level in 75% of the patients; self-confidence increased in 77% of the patients, 68% of all the patients began looking on the bright side of life; 80% of the patients marked regression of asthenic-phobic symptoms.

Based on these data we have developed a range of psycho-educational programs and guidelines for people who had experienced domestic violence. The measures mentioned above led to the increase of visiting psychotherapist, clinical psychologist and reduced the level of stigma in society.

Learning objectives

Participants will...

1. become acquainted with a range of psycho-educational programs and guidelines for people who had experienced domestic violence.
2. learn about clinical and societal outcomes of the interventions.

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I will survive! Coping with violence experienced within nursing education and socialization processes

Sub-theme: Emotional/Psychological impacts of aggression/violence

Paper

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Keywords: Foucault, Butler, nursing education, coping mechanisms, male

Introduction

Nursing has roots within religious orders and the military, and as such relies on strict education and training practices in order to prepare nurses for today's workplace (Mackintosh, 1997; MacPherson & Stuart, 1994). Nursing education and socialization processes are utilized to achieve these goals, through the use of exclusionary practices, power and discipline, and the expectation that students will conform to the desired image. The construct of the ideal nurse is historically based on a white, heterosexual female and all candidates who do not, or are unable to, meet these ideals are subject to disciplinary processes through these strategies. This paper discusses the results of a phenomenological research study focusing on the experience of male nursing students within a university education setting. The findings were informed by a theoretical framework incorporating Butler, Foucault and Queer theory. The misuse of power and discipline, and the requirement to conform to the constructed ideal of a nurse results in a culture of threat and discipline. This experience is particularly true for marginalized groups within nursing, including but not limited to men. Analysis of the data revealed five main themes; one of which was Coping Mechanisms utilized by students.

Coping Mechanisms

Many participants were overwhelmed by their experiences during their nursing education. As a result coping mechanisms were identified that assisted with their survival in the program. Many chose to surrender, to 'do whatever it took' to survive the experience. This strategy took three forms; renunciation, conforming and presenting a facade.

It's like basic training. It's going to stop. But if you keep your head down, you do what you're told and you wear the uniform and you look and sound nice and pretty, and you move like a cow when they wanted you to move like a cow. If you can conform to those things and do those things and keep your head down, stay out of trouble, then you'll get through. (Doug, Lines 1254-1261)
I think that's the attitude in general is just how you have to get through the program. To some extent you can question things and I'm not saying you have to do just everything you're told, but, in general, I would say that. (Jeremy, Lines 173-176)

Others chose a more passive approach to survival by employing strategies that aligned with the concept of avoidance. This strategy took two forms; 'getting through' and 'sit down and shut up'.

It is about getting through it. It's putting your head down and just grinding through it and if you need to step out of the way, stay out of the way of the fan. (Doug, Lines 1239-1244)
Just sit there, shut up, read the textbook when you get home. (Doug, Line 711)

The final strategy discussed was that of resistance. These strategies, that included fighting back and exiting, came to light when participants discussed the need to challenge the system and processes they were experiencing. Unfortunately these strategies often resulted in negative outcomes for the participant including withdrawal or failure from the program.

I do care about the profession, I do love nursing, I do. I just can't stand what goes on in nursing. So I have a lot of hope for the profession, really, I do. I just can't do it. (Brad, Lines 614-615)
So I think that I left because I couldn't do it anymore. I couldn't keep defending myself and I couldn't keep defending anyone else. I had no energy. (Doug, Lines 971-973)

Though these feelings were expressed by male participants, similar perceptions could have occurred with any student, regardless of gender. The feeling of hopelessness and fatality is not unique to male students. The

overwhelming sentiment expressed by these students was that of survival, no matter the obstacles, no matter the concessions that must be made, I will survive!

Discussion: Surviving the Ideal

The program and the whole process of socialization into the profession were viewed as an experience that had to be endured rather than enjoyed. Comments such as 'just get through it' and 'learning to just take it' were indicative of their renunciation and acceptance that they could not change the discourse of nursing and therefore had to endure to survive. These sentiments were echoed in the study by Ellis, Meeker & Hyde. (2006), where those interviewed felt that if they were able to conform to the requirements in the educational setting, they would succeed. They recognized that the educational environment did not reflect professional reality, indicating that post-graduation they would be free to perform in a more 'natural' way. Reid-Searl, Moxham, Walker & Happell (2010) found that students adapted their behaviours within a clinical setting to ensure a satisfactory evaluation and out of a need to 'fit-in'. This desire to assimilate was enhanced by the fear of reprisal if they failed (Reid & Searl et al, 2010). Dyck, Oliffe, Phinney & Garrett (2009) found there was extreme pressure on male students to conform and remain within the accepted construct of the nurse. Often, in response to these pressures, male students accept the need to embrace the required performativity of the role. This includes gendered aspects. In an effort to succeed they attempt to perform the role of the nurse in a feminine gendered way, irrespective of the unnaturalness of this performance. The performance is undertaken in an effort to be included, feel less isolated and with the understanding that the necessity to continue this performance will not be extended into practice. Participants spoke of self-monitoring and 'checking' themselves to ensure compliance and thus success. Through disciplinary power and the internalization of the desired construct, students ensure compliance and produce docile bodies that meet the desired ideal. As such the training is complete (Foucault, 1995).

The term socialization refers to activities whose purpose is to attempt to shape the participant on a personal level in order to reflect the behaviours and image that is deemed acceptable within the profession. These activities can include role modeling, pressures to conform, and indoctrination into the profession through experience and education. One of the many manifestations of the use of power and discipline with nursing students, within the educational and socialization environment, is a culture of threat. This creates fear but can also inspire resistance, which was one approach to survival. The results of non-conformity and resistance are evident in the experiences discussed by the participants. Cameron discussed confronting his clinical instructor when he felt he was being held to higher expectation. Doug recounted many incidents where he attempted to be the advocate for members of his class and stated he was not intimidated by the faculty. He admitted that he felt targeted as a result of this resistance and ultimately failed out of the program.

Participants felt marginalized and outside of the norm within the nursing environment. Using the concepts from queer theory, the experiences of these men resonated with the label of queer. As such they are not only positioned outside of normalcy (Britzman, 1995) but chose to fight against assimilation and gender based performance (Jagose, 1996; Butler, 2004). They chose to be critical of the norms that were being put forward as the ideal. This approach to the politics of nursing through confrontation and critique supports a queer perspective and gives rise to resistance to societal norms that are based in history and sexual identities (Stein & Plummer, 1996; Rudy, 2000). Kirsch (2000) spoke of refusing to conform as exercising personal political power and Halperin (1995) spoke of resistance as a tool against the dominant discourse with the purpose of altering the construct to be more inclusive.

Within participant's comments, it became apparent that male students compartmentalized portions of their education as well as situations within clinical in an effort to create 'safe' zones in which they were able to maintain a sense of masculinity. They referred to the more 'feminine' attributes of nursing, discussions on caring, reflective journals, and the emotions associated with nursing care as "fluff". Participants who had graduated and were actively working in a nursing role also discussed their hesitancy to disclose their profession at public gatherings. Most were quick to clarify that they were employed in specialized areas including Emergency, ICU and mental health. They indicated that when asked about their jobs they always disclosed the specialization and felt this made the role more acceptable to others. From comments made by several male participants, it appeared that they felt less self-conscious of their role when they were able to create distance from the stereotypical bedside nurse image. The specialization made their work more technical, higher acuity and thus more masculine in their view. Cooper (1996) suggested that the dominant culture has the ability to create a feeling of 'queer' for those who are not able to fit the image required by the dominant culture.

The inability to conform to the ideal results in those who are part of the marginalized group suffering stigmatization (Kirsch, 2000). While exposing the heteronormative construct that the nursing identity is based upon, participants attempted to separate themselves from this construct through forms of resistance (Green, 2002). The performativity of the feminine gendered nurse is based on a societal construct and perpetuated through the socialization processes (Butler, 2004). Performativity occurs through repetition of acts (Butler, 1988). The participants' actions reflect their attempt to meet the ideal image through 'being' a nurse, while resisting the established performativity of the ideal nurse by pursuing more masculine gendered images and specialties and distancing themselves from the so-called feminine gendered 'fluff'. Nursing is a political system and as such the participants do not wish to dismantle the system completely but ask to have a place in it. Their actions perpetuate the very thing that is oppressing them. By rejecting the 'fluff' they cling to the stereotypes that are foundational to the system and thus perpetuate the system that they condemn.

One participant discussed his dreams of a gender neutral profession. Another participant felt that he was 'paving the way' and his goal was to come back and teach and be a mentor to other males entering the profession. Yet another felt that if he fought against the image, attempting to show there were other ways to be a nurse, then this would lead to a more inclusive profession. Butler (2004) suggested that this type of questioning of the current reality and the performance of gendered behaviours can lead to a creation of a new reality. This new reality can change the accepted performance and result in the creation of an alternate but equally acceptable performance.

The need to conform to the desired performativity associated with the dominant culture is a form of social survival but can result in a loss of self (Butler, 2004). When Butler discussed the practices of drag or gender bending she explained it is not done in an effort to conform but to allegorize the way reality can be reproduced. Gender bending is considered the act of bending or disrupting accepted gender roles. Because Butler considered gender to be performative and based on societal norms, bending gender, then, is to resist these norms and explore their illegitimacy (Butler, 1990). Bending gender can also be seen as a political act, as it serves to disrupt power dynamics within society. Lorber (1994) argued that this is not enough, that drag perpetuates the binary that Butler argued against. Lorber supported the removal of all gender based performance, taking on a more androgynous non-gendered persona. Doing so would force society to see the person as they are and not a performance of a gender. A study by Baker (2001) suggested that male nurses who display more androgynous qualities have less role strain, while a study by Liminana-Gras (2013) indicated that male nurses, who are viewed as successfully integrating into the nursing culture and advancing within the profession, show below average conformity to traditional male gender norms.

Often those who practice drag are labelled unreal and as a result feel marginalized and oppressed. In an attempt to survive they tend to live in communities that allow them to see themselves as real and feel accepted (Butler, 2004). There is evidence in the literature suggesting that male nurses tend to gravitate to specialty areas of nursing. In these areas, working with other men, they are able to perform nursing in such a way that it is within the 'normal limits' of the accepted image but with a masculine gendered performance associated with it. Some participants who were practicing as graduates indicated they were working in areas that were specialized and there were a greater number of male nurses working in those areas. They expressed their comfort with working with other men and indicated that they felt they could be more 'themselves' and felt less pressure to assume the feminine gendered performance that was expected in settings with a majority of women. Many felt that the ability to temper the gender performativity required by nurses with a masculine performance resulted in a greater satisfaction and comfort level with their role. The melding to the masculine and feminine attributes created a more gender neutral nurse.

Conclusion

Experiences of the participants revealed educational and socialization processes that supported an ideal image of nursing not based in reality but in the gendered social construct of the ideal nurse. The gendered construct of society is the foundation of how we perceive and experience our reality and the nursing ideal is just one example of how that perception is tainted by the binary. There are indications that various forms of power are utilized to construct and control nursing students to meet the desired gendered performativity of a nurse. The enforcement of the ideal is achieved through the creation of a fear based education system and the perpetuation of the feminine ideal. Male students feel marginalized and have a sense of 'being out of place' within the nursing profession and they strive to find a place in which they feel both part of the profession and yet still maintain their masculine attributes. The experiences of the participants brought to light their desire to conform but simultaneously their desire to resist assimilation and loss of self. The ultimate goal is survival of the ideal. Though this research focused on the male nursing student experience, the findings suggest that all students, who do not meet the ideal image within nursing, are subject to similar experiences

of disciplinary processes and marginalization. It is through discussing these processes, and being aware of the strategies utilized, that nursing faculty can work to change the education and socialization processes to create a more diverse and accepting environment. Knowledge of these coping mechanisms will help faculty identify students who are at risk and limit the psychological impact of the disciplinary culture experienced.

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Learning objectives...

Participants will...

1. identify the impacts of the education and socialization processes experienced by nursing students.
2. understand the mechanisms utilized by nursing students to cope with the effects of violence and marginalization.
3. generate discussion on strategies that could be employed to create a more diverse and accepting educational environment and profession.

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Aggression, traumatic material, accountability and compassion among child protection workers: the intervening effect of professional identity

Sub-theme: Emotional/Psychological impacts of aggression/violence

Paper

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Keywords: Aggression, accountability, compassion fatigue, child protection workers, professional identity

Background

Child protection workers (CPW) are among the most exposed workers to workplace aggression. On a daily basis, they must deal with the aggressive behaviours of their clientele, all while being exposed to stories of trauma, abuse, neglect, violence and other cruelties. In addition, these workers are held accountable for the professional decisions they make in the course of their duties.

Consequently, providing public service can become a burden for CPW. Indeed, negative outcomes such as compassion fatigue (CF) have been associated in the literature with exposure to these work-related stressors. However, professional identity (PI), which refers to a system of meanings and values associated with the worker's roles, may intervene in the relations between work-related stressors and compassion fatigue. Therefore, this presentation focuses on how adherence to professional identity may help CPW to cope with exposure to aggression, traumatic material and accountability.

Objective

The main objective is to evaluate the effects of exposure to workplace aggression (as measures of primary and secondary trauma), time of exposure to traumatic material (as measure of vicarious trauma) and felt accountability on CF among CPW. The second objective is to assess the intervening effects of adherence to the PI between these stressors and CF.

Methods

Conducted with a representative sample of 301 CPW, the effects to stressors on CF and the intervening effects of PI are evaluated in a structural equation model. The indirect and moderating role of PI was tested.

Findings

Exposure to workplace aggression and felt accountability had positive direct effects, while exposure to traumatic material had no effect. Adherence to PI had negative direct effects on CF suggesting that adherence to PI may be a protective factor of CF. Adherence to PI also partially accounted for the positive relation between felt accountability and CF, which is to say that felt accountability indirectly affects CF by decreasing adherence to PI. The more participants felt accountable, the less they adhere to PI, the more they experience CF. Finally, low adherence to PI amplified the positive relation between exposure to workplace aggression and CF.

Implications

Findings strengthened the integration of a fourth variable in the CF model: accountability stress. Child protection organizations should develop strategies to foster adherence to PI. Adherence to PI should be assessed when providing support to CPW victims of aggression. Felt accountability should be addressed as an occupational stressor resulting in similar psychological consequences as exposure to aggression.

Learning objectives

Participants will...

1. realize that child protection organizations should develop strategies to foster adherence to PI since it may represent a protective factor for psychological wellbeing at work.
2. appreciate that adherence to PI should be assessed when providing support to CPW victims of aggression since low adherence amplifies stress emanating from exposure to aggression.
3. acknowledge that felt accountability should be addressed as an occupational stressor resulting in similar psychological consequences as exposure to aggression.

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Wounded Healers: Addressing the psychological impacts of violence and trauma in the nursing profession

Sub-theme: Emotional/Psychological impacts of aggression/violence

Paper

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Keywords: Post-traumatic stress disorder (PTSD), violence, trauma, psychological hazards, occupational health and safety

Background and context

Discussions related to psychological hazards in healthcare have occurred largely within the confines of workplace violence and trauma. While there is no shortage of research examining the prevalence of workplace violence in healthcare settings, inadvertently little attention has been paid towards examining the inter-dependent relationship between violence and the psychological toll it takes on nurses. With increasing disability and absenteeism rates due to mental health, the Manitoba Nurses Union (MNU) spent over a year conducting research to identify the ways in which violence, among other work environment factors, influence the development of post-traumatic stress disorder (PTSD) in the nursing profession.

This paper outlines the findings from MNU's PTSD research report with an emphasis on workplace and its interdependent relationship to PTSD in the nursing profession. The MNU used its research to achieve tangible successes in improving access to workers' compensation for psychological injuries under the *Workers Compensation Act*. An overview of MNU's lobbying efforts and key organisational recommendations resulting from this research are also emphasized in this paper.

Methodology

A literature review was completed to identify occupational factors influencing PTSD in nurses. Qualitative and quantitative data derived from six regional focus groups (N=22) and a structured questionnaire (N=1,205). The focus groups were particularly useful as they provided an opportunity for nurses to share detailed accounts of their personal experiences associated with violence and trauma, which substantiated findings generated from the literature. The accumulation of research served as the foundation to complete a thematic analysis to help determine which unique work environment factors have the most influence on PTSD nurses, the ways in which nurses view and respond to workplace trauma and violence, and to help inform healthcare policy and organizational recommendations.

Findings

The occurrence of workplace violence in healthcare is not a new phenomenon especially for Manitoba's nursing workforce. In 2011, MNU released a violence research report which identified that over half of nurses have been physically assaulted, 17 percent have dealt with an individual with a weapon, and over 70 percent have been verbally abused (MNU, 2010). It was not until MNU completed its PTSD research that the connection between workplace violence and its detriment towards nurses' psychological health was clearly distinguished. The literature review was valuable in identifying that in addition to unique work environment factors, such as emotional labour and exposure to critical incidents, workplace violence continues to be the most compounding risk factor influencing PTSD in nurses. It was found that it is not only the direct experience of violence that increases the risk of PTSD in nurses, but rather equally the threat of violence (Jacobowitz, 2013). One study (Jacobowitz, 2013) specifically noted that the "frequent exposure to workplace violence and the threat of violence increases stress levels in nurses and the risk of PTSD, and the threat of violence alone can be more impactful than having gone through the experience" (p.789). In surveying its members, MNU found that one in four nurses in Manitoba consistently experience common PTSD symptoms, especially nurses working in areas densely populated with violence and trauma. This is representative of the 37 percent of nurses working on psychiatric units, 31 percent of long term care nurses and 30 percent of ER nurses who experience physical violence on a weekly basis. Similarly, research external to MNU shows that 72 percent of

nurses do not feel safe from assault in their workplace given the fact that nurses are more likely to be attacked at work than any other professions including, police officers and prison guards (ICN, 2009).

In addition to the threat and actual experience of violence, research identified the breadth of exposure to violence and trauma can have profound impact on the risk of PTSD. As the length of exposure to suffering and trauma is prolonged, the intensity and breadth of stress increases for nurses (Meadors and Lamson, 2008), which greatly impacts the risk of PTSD development, especially for nurses who continue to work in environments densely populated with trauma. This is imperative to note as nurses working in areas inundated with high levels of trauma and violence face a higher risk of developing a more severe reaction to PTSD than individuals permitted to recover away from high level of traumatic and violent activity (Wykes and Whittington, 1998). Nurses are not only victims of violence, but they are also witnesses of violence and vicarious trauma. Both the literature review and MNU's survey confirmed that the most common triggering events for PTSD in nurses include witnessing abuse or death of a child, encountering abuse from patients or patients' families and witnessing the death of a patient as a consequence of a medical procedure (Powell, 1996). However because PTSD in nurses is cumulative, with frequent exposure, post-traumatic stress symptoms may accumulate and add to the development of PTSD.

What is most significant to acknowledge is that unlike non-healthcare professions, it is the prolonged, cumulative exposure to violence and trauma that influences the rate of PTSD in nurses and their ability to recognize violence as a psychological health and safety hazard. This was substantiated in MNU's focus groups and survey in which it was found that nurses have come to accept violence as part of the job and over time, they are not able to clearly recognize the personal psychological ramifications of experiencing and witnessing violent and traumatic events. The normalization of workplace violence places nurses at a greater vulnerability of perpetuating the psychological impacts of workplace violence if they do not recognize what a serious threat this poses to their physical and mental wellbeing.

Based on the research findings, MNU found it imperative to analyse the data through an organisational lens in which the emerging legal responsibility of employers to protect employees' mental health was considered the most impactful prevention model to address PTSD in nurses. This analysis helped form the foundation of MNU's recommendations and aggressive lobbying campaign to improve legislative and regulatory frameworks related to health and safety, and to ensure there are adequate, accessible psychological health supports in every healthcare facility. While Manitoba currently has strong violence prevention policies in place in all healthcare facilities, there is a dearth amount of adequate supports tailored for the psychological toll violence and trauma places on nurses. When focus group participants were asked if any debriefing or psychological supports were provided after a violent, traumatic event, more often than not, it was confirmed that either nothing was made available, there was a brief discussion with their immediate supervisor, or they had to wait weeks to access supports such as counselling services through the Employee Assistance Program. Despite common criticisms related to debriefing and critical incident stress models, Manitoba's nurses continuously commend these models as the most effective way to address trauma and violence in the nursing profession.

The same disparity of recognizing the unique development of PTSD in nurses was noted in Manitoba's workers' compensation legislation and policies in which there is a greater emphasis for nurses to prove a causal link between one single event and their psychological injury. As previously stated, nurses' prolonged, cumulative exposure combined with their normalization of violence and trauma makes it extremely challenging to pinpoint one acute event as the source of their PTSD or psychological injury. Furthermore, there is a wide scope of subjectivity used throughout the compensation claim adjudication process in determining if an event was indeed "traumatic enough" to cause PTSD. This was the most challenging issue for Manitoba's nurses as there have been instances where a claim at the appeals commission level was approved under the exact same criteria that was used to deny the claim the first time.

Discussion

Based on the survey and literature review, MNU synthesized a report with a series of recommendations that were presented to the Minister of Labour and launched an aggressive lobbying campaign to improve psychological health and safety for nurses amongst all other healthcare professionals. MNU's hard-earned efforts came to fruition when the provincial government introduced presumptive-PTSD legislation that was inclusive of nurses, setting precedent as a best practice for nursing unions across Canada. This legislation formally recognizes the cumulative exposure to trauma by removing the requirement for nurses to prove a causal relationship between one traumatic event and their PTSD diagnosis.

In addition to the headway MNU made advocating for improved legislation, the research report proposed the following recommendations to address the psychological impacts of violence at an organisational level: 1) develop comprehensive organizational supports; 2) foster healthy work environments and practice settings in healthcare; 3) provide ongoing education related to mental health and prevention to managers and employees; and 4) ensure there is an effective tracking system in place related to workplace psychological hazards and injuries. MNU's recommendations emphasize the necessary requirement to respond to psychological health and safety through a tri-partite agreement between government, labour and the employer. It is through this collective force that the mental health of nurses and healthcare professionals will be instilled as a priority in the healthcare sector.

Ongoing efforts

Having achieved success in improving the regulatory and legislative framework surrounding compensation for psychological injuries, MNU continues its campaign to encourage the provincial government to legally recognize psychological and psychosocial hazards as integral factors for a comprehensive occupational health and safety legislative framework. Similar to the success MNU achieved for workplace violence prevention policies, MNU will be advocating for a legal requirement for each healthcare facility to have a psychological health and safety policy in place along with accessible psychological supports such as debriefing and mental health awareness training. As a union, MNU is determined first and foremost to educate its members and change their perceptions of violence and trauma, namely in which that it is no longer "part of the job" and to understand that their mental health is of equal importance and priority as their physical health. MNU's commitment to member engagement and awareness continues to drive MNU's fight in protecting the health and safety of its members and to make workplaces safer for every nurse and the patients they care for.

Conclusion

Regulatory changes were an important and significant victory for nurses across Manitoba, and MNU's research highlighted the imperative role and responsibility government, unions and employers have in instilling a psychologically safe work environment for healthcare settings. The work to improve the psychological health and safety of nurses and all health professionals is not an easy feat and the fight is far from over. It is a realistic to expect that workplace violence and trauma will never be completely eradicated from the nursing profession, however it remains paramount for both healthcare policymakers and employers to implement a robust psychological health and safety prevention strategy that explicitly addresses and prevents the psychological hazards prevalent in healthcare settings. Psychological health and safety can no longer afford to be viewed as an individual issue, but an organisational priority, as the future stability and quality of healthcare systems rely on the physical and psychological health of those who provide care.

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Learning objectives

Participants will...

1. understand the unique psychological impacts of workplace violence and trauma in the nursing.
2. understand the interdependent relationship between unique work environment factors and PTSD development in nurses.
3. be able to elucidate what effective legislation and workplace health and safety standards entail for psychological health and safety in healthcare work environments.
4. Understand that improvements to workplace psychological health and safety can be made through a tri-partite approach between government, employer, and labour stakeholders.

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Debriefing after manual restraining in child psychiatric inpatient care

Sub-theme: Emotional/Psychological impacts of aggression/violence

Poster

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Keywords: Manual restraint, debriefing, child psychiatric inpatient care

Background

Child psychiatric inpatient care is usually voluntary. Manual restraining is only occasionally used to prevent the child to harm her/himself and/or others in child psychiatric inpatient care. Most of the children describe coercive and restrictive measures (manual restraining or seclusion) with negative terms, experience them to be painful and consider them to be a punishment.

Study aim

The purpose of the study is to describe how the children experience debriefing after manual restraining and how nurses have documented these situations.

Methods and data collection

The data were collected in Kuopio University Hospital during 2009-2012. Altogether 457 treatment periods (379 children) were carried out in the inpatient units and of 57 children faced manual restraining first time. Of all the 57 children, 34 (59.6%) were interviewed. During the interviews 19 children were asked if the staff had discussed about the restraining situation with them. Three patients were not interviewed regarding debriefing because of their restlessness and unwillingness. With 12 children (35,3%) the interviewer asked only what had happened after the restraining. These children did not specify debriefing discussion, just what they were doing like showering, reading or playing some game. In addition, nurses' documented notes (n=34) were analysed. The data were analysed using content analysis.

Findings

Every seventh child (15%) had experienced restraining during the hospital stay. Most were boys (n=30, 88%) who had externalizing disorders (66%). Mean age was 9,3 years (age range 6 –13). In all cases the duration of manual restraining lasted more than 10 minutes. Only six children (17.6%, n=6/34) informed that debriefing of the situation had taken place afterwards. Nurses reported that debriefing was used in 44% (n=15) of the cases. Of all the children interviewed, 11 did not remember this discussion and only in four cases both the staff and the child agreed with each other.

Implications

To our knowledge, this study is the second one to inform how children experience manual restraining. Only every fifth child could tell that debriefing had taken place afterwards. The debriefing sessions had also been infrequently documented by the nurses. Restraining situations should be addressed immediately after the situation but preferably also later during the next day. There are indicative data showing that mechanical restrained patients have been inadequately debriefed. However, the negative impacts of restraining and the importance of good practice to handle the situation afterwards have been recognized. As the use of restrictive interventions is in some situations necessary, debriefing of the experience is essential in order to help the child to understand what had happened and why to avoid additional traumatization. Further studies are needed to understand the experiences the children are facing during manual restraining. This study also showed that more attention should be paid to the nursing documentation.

Learning objectives

Participants will...

1. realise the impact of manual restraining children experience.
2. understand the importance of debriefing after restraining.

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Stress and strain on forensic psychiatric nurses: Violence just one part of the picture

Sub-theme: Emotional/Psychological impacts of aggression/violence

Paper

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Keywords: Psychiatric forensic nursing, aggression, violence, empathy, Post Traumatic Stress Disorder, Compassion Satisfaction, Burnout, and Compassion Fatigue

Background

Nursing forensic patients entails a fundamental conflict between caring for patients whilst upholding the custodial regulations stipulated by the forensic institution. The types of patient behaviour forensic psychiatric nurses are exposed to such as violence, aberrant sexual behaviour, obscene language, manipulation, aggression, or patients' projective mechanisms may induce psychological stress.

Aim

This study aimed to assess the psychological impact of forensic psychiatric work on nurses, to establish which variables are associated with the psychological impact of forensic psychiatric work on nurses.

Methods and materials

This cross sectional survey was conducted employing convenience samples of forensic psychiatric nurses in Germany and Switzerland. The self reporting questionnaire comprised demographic questions, the Professional Quality of Work Life Survey, and the Questionnaire on Inter-Professional Collaboration which were considered as the independent variables. To measure psychological stress as the dependent variable the Impact of Events Scale Revised (representing Post Traumatic Stress Disorder - PTSD) and the Professional Quality of Life instrument (representing Compassion Satisfaction, Burnout, and Compassion Fatigue) were utilised.

Results

One hundred and seventy two forensic and 31 acute psychiatric nurses returned their questionnaires giving rise to a response rate of 47.1%. The mean age of the nurses is approximately 40.5 years and 49.1% are female. The mean tenure of the nurses in nursing is almost 19 years and tenure in their present position is just over 9 years. Descriptive statistics demonstrate that the 57.6% of the forensic nurses showed low Compassion Satisfaction, 6.4% high Burnout, and 9.9% high Compassion Fatigue.

Thirty forensic nurses from a total of 149 for whom data were available show a fully fledged PTSD giving rise to a prevalence of 20.1%. Logistic regressions demonstrate that increments in current tenure, being female, and lower intrinsic rewards are associated with the increased likelihood of experiencing low Compassion Satisfaction, high Burnout, or Compassion fatigue. Further analysis revealed that the negative psychological impact of forensic psychiatric work is only partially attributable to violent and aggressive behaviour such as auto-aggression, sexual harassment, or suicide acts.

Implications

Forensic nurses experience a considerable amount of stress suggesting psychological risk to the nurses' wellbeing and possible impairments to patients' care. Superiors are advised to be attentive to signs of psychological stress in nurses and to deploy measures to combat stress and strain.

Learning objectives

Participants will...

1. learn that aggression and violence in forensic nursing settings contribute to nurses' stress and strain.
2. learn which other stressors may be as stressful if not more stressful than violence.

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The importance of friends as support network for rape victims

Sub-theme: Emotional/Psychological impacts of aggression/violence

Paper

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Keywords: Sexual assault, rape, support network, friends

Abstract

Since 1993, the World Health Organization recognizes sexual assault as a public health problem. It can also be defined as gender violence, being influenced by gender relations and predominantly perpetrated by men against women. Even though all women are in risk for sexual violence, researches show that young women are in greater risk for rape. It is also known that young women are more likely to disclose their experiences to a family member or a friend. In this interpretive descriptive study, 10 women participated in an individual, semi-structured interview related to their experiences of rape and the importance of having a family network. Data were analyzed using a thematic analysis approach. In stories told by women, friends were described as an important part of their recovery and even defined by some as family. On the other hand, the reports also showed that friends are in many ways unprepared to support rape survivors. The aim of this work is to discuss the importance of friends as a support network for rape victims and its limitations, focusing on how they complement the assistance of the health system.

Learning objectives

Participants will...

1. be able to discuss the importance of friends as a support network for rape victims.
2. be able to discuss the assistance given to rape victims.
3. be able to discuss the importance of a support network to complement the assistance of the health system.

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Patients' perspectives of involuntary referral to a psychiatric hospital: a grounded theory study

Sub-theme: Emotional/Psychological impacts of aggression/violence

Paper

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Keywords: Involuntary referral, restraint, grounded theory, patients' beliefs

Background

In Switzerland nearly 50,000 people yearly are hospitalized in due to psychiatric disorders with about 38% of these on an involuntary basis. Although involuntary referral to psychiatry is considered as standard care in psychiatric settings it has multiple consequences affecting all actors, for example 1) The patient who undergoes arduous treatment, both physically and mentally; 2) Nurses who are obliged to provide care against the patient's will, which possibly endangers their 'good care' image and may generate ethical conflicts; 3) Patients' families who do not always understand the justification for such measures. The expected beneficial effect of involuntary hospitalization is often jeopardized by patients' experiences of feeling coerced and may endanger the therapeutic alliance.

Research question

What are the beliefs, attitudes and behaviours of patients involuntarily hospitalized in a psychiatric hospital?

Method and sample

The grounded theory approach was utilized to discover patients' experiences. Grounded theory is based on the assumption that social actors are the only bearers of the meaning of their experience. The theoretical sample of participating patients was drawn from hospitalized adult patients' involuntarily referred to psychiatric hospitals.

Results and implications

Eleven patients were interviewed, (nine men and two women). Preliminary results suggest four experiential categories: 1) The experience of coercion itself, 2) beliefs about the hospitalization mode, 3) impact on the interaction with the environment and 4) patients' attitudes. The experience of coercion found in this study - a predominance of anger and sense of injustice - is consistent with findings in the literature. Patients experiencing involuntary referral to a psychiatric hospital fight to find their identity and try to find an adequate attitude and an action plan to cope with the situation. The study findings are expected to help encourage the prediction and explanation of behaviours of patients forced into acute psychiatric units, to contribute to the development of nursing theory, to be of utility in allowing stakeholders to understand the phenomenon, and to guide research in the analysis of the behaviour patients experiencing coercion.

Conclusion

Involuntary referral to a psychiatric hospital has a significant impact on the "patient's journey". Giving the patients their say may improve the situation.

Learning objectives

Participants will...

1. appreciate the impact of involuntary referral as experienced by patients.
2. develop sense around what is seen as unfair and arbitrary for the patient and decrease the traumatic consequences for him.

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Characteristics of Female Perpetrators in Treatment Programs for Domestic Violence

Sub-theme: Emotional/Psychological impacts of aggression/violence

Poster

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Keywords: Domestic Violence, Batterer Intervention Program, Johnson's Typology, Mental health, Physical health

Background

Batterer Intervention Programs (BIPs) offer services to men and women who have been involved in domestic violence perpetration. Traditional BIPs were designed for men however a significant percentage of these offenders are women. Understanding of the characteristics of women offenders has been limited, therefore additional information is needed to understand the women who are in these programs and the context of these violent events. Furthermore, classification of women who use violence can lead to a better understanding of it no matter whether it is family or agency violence. This study aims to explore characteristics of women receiving services at BIPs.

Methods

This was a mixed methods study with both qualitative and quantitative data. 39 women enrolled in BIPs and four treatment facilitators of BIPs participated in this study. Quantitative data included physical and mental health status, abuse history and reasons for perpetrating partner violence. In-depth, individual semi-structured interviews with study participants yielded qualitative data. Atlas.ti was used in data management and thematic analysis was conducted. Johnson's typology was used as a framework to classify the characteristics of the intimate violence of which the women were convicted.

Results

The mean age of women interviewed was 30.62 years (Range = 20-56). Most of the sample was White (46.2%), followed closely by African American/Black (35.9%) followed by Hispanic/Latina (10.5%) or "other" race (5.1%). There were varying levels of educational achievement with 33.3% having completed at least a high school education. Most women enrolled in BIPs in both sites had children (71.8%). The physical health of these participants was below that of the general population in 33% of women. Women were at increased risk of having physical injury resulting from domestic violence when compared to their partners both in frequency (62% vs. 54%, $p=0.007$) and severity (46% vs. 21%, $p<0.001$). The mental health status of these women were also explored and 38% of women had a mental health status below that of the general population. Approximately 40% of the women suffered from post-traumatic stress disorder, 40% psychosis, 35% generalized anxiety disorder, 30% alcohol abuse, 22% depression, and 15% substance use disorder. Among 31 women who were involved in incidents with a partner, 16 were classified as situational couples violence (mutual violence) while 15 were classified as violent resistance. No women were classified as being "batterers" the most expected category among male offenders.

Conclusion

This paper highlights characteristics of women in BIPs. Findings demonstrate mental health and physical health issues present in this population. Understanding the characteristics of women in these programs can help to improve service delivery to better address their needs.

Learning objectives

Participants will...

1. be able to identify the characteristics of women in Batterer Intervention Programs.
2. be able to discuss the mental and physical health issues that are prevalent in women offenders!

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The impact and support experiences of personnel following occurrences of work related aggression and/or violence: A transatlantic comparison

Sub-theme: Emotional/Psychological impacts of aggression/violence

Workshop

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Keywords: Physical injury, Psychological impact, Financial impact, Staff support

Abstract

Work related violence toward healthcare staff is pervasive across service settings internationally, and persistent across time as evidenced by empirical studies in Japan (Inoue *et al.*, 2006), New Zealand (Baby *et al* 2007) Europe (Nijman *et al* 2007), Ireland (McKenna 2008) South Africa (Bimenyimama *et al.* 2009), and Israel (Yarovitsky & Tabak, 2009).

Irrespective of geographical or clinical setting, the impact of such occurrences diminishes the quality of working life for staff, compromises organizational effectiveness and ultimately impacts negatively on the provision of care services (McKenna 2008). However, the post-occurrence experience of the individual varies greatly between and within geographical jurisdictions as a function of professional traditions and cultures, societal tolerance (or intolerance) of work-related violence, provision and acceptance of support, organizational culture and regulations governing disability payments. This diversity in practice related to workplace assault is compounded by the emphasis on the physical aspects of the impact of occurrences of violence in early studies which highlighted the scale and magnitude of physical injuries, but failed to acknowledge the significant emotional, biophysiological, social and financial sequelae following such occurrences.

The initial component of this two part workshop will present a comparison of transatlantic empirical evidence from studies conducted in the US and Ireland which will explore the key themes of prevalence, physical injury, emotional distress, financial impact, and the provision of support to the personnel involved. Similarities and differences in the findings of these two studies will be compared and contrasted.

The second component will draw upon the experiences of the vastly geographical diverse participants attending the session and explore the strengths and limitations of support structures from diverse geographical perspectives, in order to:

- Expand our understanding of current practice in relation to workplace violence and the implications for organizational and professional practice.
- Explorations will include the impacts of violent episodes, the effects of the assault, responses of the organization, and the structures of post-occurrence professional and/or governmental support offered.
- This interactive engagement will place emphasis on examples of best practice and consider how this shared learning might be utilized to improve practice beyond the conference and inform the formulation of best practice.

Learning objectives

Participants will have the opportunity to...

1. expand their understanding of the physical, emotional and financial impacts of encountering work related aggression and/or violence.
2. expand their understanding of the strengths and limitations of current practice in the provision of post-occurrence professional and/or governmental supports
3. engage in an interactive forum with colleagues exploring examples of best practice with an emphasis on how this shared learning might be utilized to improve practice beyond the conference.

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The spiral effect of violence and conflict on psychological and interpersonal health conditions of nurses

Sub-theme: Emotional/Psychological impacts of aggression/violence

Paper

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Keywords: Stress in nursing, Anxiety, Depression, Somatization, Hostility, Interpersonal-Sensitivity

Introduction

In recent years a large body of literature has underlined the necessity to analyse stressful and harmful consequences related to violent and conflictual workplaces (Hershcovis et al. 2007; Aquino and Thau, 2009), and the increasing issue of aggression in healthcare services has raised international interest (Beech and Leather, 2006; Gillespie et al., 2010). The changing in the healthcare system, characterized by new therapeutic possibilities, has increased patients' demands without improving resources. This phenomenon has influenced both relational skills and well-being among health professionals (Panagopoulou et al., 2015) leading to more complex and, in some cases, conflictual experiences.

Despite the increasing interest in this issue, the research in this field is underdeveloped. Firstly, the frequency of incidents and assaults are only partially documented, mainly because the stigma of victimization (i.e. shame, fear of judgement and lack of support from co-workers) leads the nurses to under-report abuses (Rippon, 2000); consequently, the scale of the phenomenon and its impact on nurses' perceived well-being are still poorly understood. Secondly, the analysis of violent and conflictual experiences in the workplace has been limited by the lack of a clear and univocal definition of what constitutes aggression (Rippon, 2000; Beech and Leather, 2006; Piquero et al., 2013). Firstly, Dollard and colleagues (1939) defined aggression as "an act whose goal-response is injury to another organism". Buss (1961) distinguished angry aggression (based on the emotion of anger) and instrumental aggression (without strong emotional basis), excluding both the concept of premeditation and verbal aggressions. Moreover, in the occupational literature, workplace aggression has been defined from different frameworks. For example, Keashly and colleagues (1994) paid more attention to emotional abuse, whereas Robinson and Bennett (1995) suggested that workplace aggression might be explained as a voluntary behaviour that violates significant organizational norms, threatening the well-being of the organization and/or of its members. Nevertheless, the most used description referred to "incidents where staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health" (Wynne et al., 1997), and the nursing profession is considered particularly exposed (Budd, 1999; Leather, 2001; Murphy, 2004; Beech and Leather, 2006; Panagopoulou et al., 2015). The relationships with patients and their relatives emerged to be the most frequent sources of violence and abuse toward nurses (Farrell, 1997, 1999, 2001; Gillespie, 2010; Pai and Lee, 2011; Piquero et al., 2013). However, research also suggests that verbal abuse towards nurses are carried out primarily by other nurses and physicians (Farrell, 1997, 1999, 2001; Pai and Lee, 2011; Rowe and Sherlock, 2005), and that the relationships with supervisors are also significant potential source of stress linked to emotional abuses, humiliations, intimidations, and invasions of privacy (Tepper, 2000).

Research considers conflict in the workplace as a specific source of pressure for nurses, and developed specific measurement tools for the assessment of nurses' perceived work-related stress. In particular, Gray-Toft and Anderson (1985) developed the original version of one of the most popular measurement tools: the Nursing Stress Scale (NSS), which explores the dynamic relationship between individual and situational characteristics and the processes of cognitive appraisal of demands, and analysing their effects on nurses' self-reported health conditions. The NSS was composed of 46 items and had eight subscales. Work-related sources of pressure were explored by the four subscales of *Work load*, *Uncertainly concerning treatment*, *Inadequate Preparation and Death and Dying*, while the sources of pressure connected to conflictual relational experiences were assessed by the subscales of *Conflict with physicians*, *Conflict with other nurses* and perceived *Lack of Support*. Afterward, French and colleagues extended this scale, paying more attention to the conflictual dimensions that should be

addressed and focused in the nursing profession. The Expanded Nursing Stress Scale (ENSS; French *et al.*, 2000) considered two more relational issues (*Conflict with patients and their families* and *Perceived Discrimination*) and transformed the scales of *Lack of Support* and *Conflict with other nurses defining them Problems with supervisors and Problems with peers*.

In addition to research focused on the analysis of sources of pressure, a large body of literature underlined both the antecedents, as well as the consequences related to workplace violence in health care settings (e.g. Merecz *et al.*, 2009; Gillespie *et al.*, 2010, Pai and Lee, 2011; Zhou *et al.*, 2015). In regards to the antecedents of experiencing a conflictual workplace, both individual (e.g. age, sex) and situational (public/private workplace, type of ward) factors were defined as predictors for workplace aggression (Martinko *et al.*, 2002; Hershcovis *et al.* 2007; Gillespie *et al.*, 2010). For example, male nurses and younger nurses were found to be significant predictors of higher risk of reporting violence (Pai and Lee, 2011; Piquero *et al.*, 2013; Wei *et al.*, 2016). Moreover, concerning the consequences of perceived workplace violence, literature has also underlined, beyond physical injuries and temporary or permanent disability, the impact of verbal and physical abuses toward nurses in terms of negative job performance (i.e. medications errors), job dissatisfaction, leaving intention (Quine, 2001; Merecz *et al.*, 2009; Zhou *et al.*, 2015) and increasing sickness absence (Nijman *et al.*, 2005). Studies also supported the association of perceived workplace violence with burnout (Merecz *et al.*, 2009; Galián-Muñoz *et al.*, 2016), post-traumatic stress disorders (Pai and Lee, 2011), depression (Quine, 2001; Aquino and Thau, 2009; Piquero *et al.*, 2013) and somatization (Merecz *et al.*, 2009; Zhou *et al.*, 2015). Occupational stress literature also shows that perceived injustice was significantly related to increased anger levels (Zhou *et al.*, 2015) and disruptive and aggressive behaviours (Baron *et al.* 1999) among workers, suggesting a relation between aggressions and counter-aggressions. Thus, perceived levels of stress related to conflictual relationships may have a predictive role not only for the risk of anxiety and depression but for the risk of interpersonal diseases too (i.e. hostility and interpersonal sensitivity), and this has led to our hypotheses.

Therefore, according to the previous literature and the critical points reported above, the aims of the present research were:

- to explore nurses' perceived levels of stress related to conflict experiences in workplace, focusing on specific sources of conflict (e.g. relationship with Physicians, with Patients and their families, with Supervisors, with Peers, and Discrimination);
- to explore nurses' perceived levels of psychological disease (Anxiety, Depression, Somatization) and interpersonal disease (Hostility and Interpersonal-Sensitivity);
- to analyse the effects of perceived levels of stress related to conflictual relationships on nurses' self-reported psychological and interpersonal health conditions.

Material and methods

Sample

The present study was carried out in a sample of 200 nurses of Southern Italy, recruited from Hospitals of the Public Health Service. Multistage sampling was used in the selection of the study sample considering as inclusion criteria: geographic areas and different hospitals from public health service. A total of 200 out of 250 questionnaires distributed were returned and considered valid (response rate=80%). 43% (N=86) were men, 57% (N=114) were women. The ages ranged from 20 to 65 years (M=45.9, SD= 10). With respect to the work characteristics, 88.4 (N=167) works since more than 7 years (working Seniority); 92% (N=184) had full-time contract, 89% (N=178) had a permanent contract; finally, 70.4% (N=140) performed night shifts.

Measures

Demographic Characteristics

Demographic Characteristics information were included in a section dealing with respondent's individual characteristics (e.g. sex, age) and occupational characteristics (e.g. working seniority, night shifts).

Expanded Nursing Stress Scale

Self-reported perceived levels of stress related to conflictual relationships were assessed by the five subscales of Conflict with physicians, Problems with Peers, Supervisors, Patients and their Families and Discrimination from the Expanded Nursing Stress Scale (ENSS, French *et al.*, 2000). Cronbach's α for all the subscales reaches satisfactory values (Conflict with physicians: $\alpha=.79$, Problems with Peers: $\alpha=.85$, Problems with Supervisors: $\alpha=.81$, Patients and their Families: $\alpha=.87$ and Discrimination: $\alpha=.87$).

Symptom Checklist 90-R

Self-reported health conditions were evaluated by the five subscales of Anxiety (*Cronbach' α* =.88), Depression (*Cronbach' α* =.90), Somatization (*Cronbach' α* =.88), Hostility (*Cronbach' α* =.85) and Interpersonal-Sensitivity (*Cronbach' α* =.84) from the Italian Version of Symptom Checklist 90-R (SCL-90-R, Derogatis, 1994; Prunas *et al.*, 2010).

Data Analysis

Preliminary, Descriptive Statistics and Pearson's Correlations Analyses were carried out to analyse mean, standard deviations and correlations between study variables, socio-demographic characteristics and employment information.

Firstly, the independent variables of Conflict with physicians, Problems with peers, supervisors, patients and their families and Discrimination, and the dependent variables of Anxiety, Depression, Somatization, Hostility and Interpersonal-Sensitivity were dichotomized in terms of low and high levels split by means, considered as cut off-points (Conflict with physicians: $M=8.5$, Problems with Peers: $M=7.3$, Supervisors: $M=12.6$, Patients and their Families: $M=16.9$, Discrimination: $M=3.8$; Anxiety: $M=.30$, Depression: $M=.36$, Somatization: $M=.36$, Hostility: $M=.30$, Interpersonal-Sensitivity: $M=.29$).

Secondly, frequencies and percentages of nurses' perceived levels of stress related to conflictual relationships (Conflict with physicians, Problems with peers, supervisors, patients and their families, and Discrimination) and presence of self-reported diseases (Anxiety, Depression, Somatization, Hostility and Interpersonal-Sensitivity) were explored.

Finally, multivariable associations (Logistic Regression Analysis, Method: Forward LR, First indicator contrast) between independent variables and dependent variables were tested to analyse the groups with the highest likelihood reporting poorer health conditions. In these models, $p<.05$ and $p<.001$ were used as entry criterion and odds ratios and 95% confidence intervals were compared. All the statistical analyses were treated using IBM SPSS Statistics Software, Version 20.

Results

Descriptive Statistics and Correlations

Table 1 presents means, standard deviations and correlations between the study variables (Conflict with physicians, Problems with peers, supervisors, patients and their families, Discrimination as well as Anxiety, Depression, Somatization, Hostility and Interpersonal-Sensitivity), socio-demographic characteristics (sex, age) and employment information (working seniority and night shifts).

Considering correlation analyses, data demonstrate the absence of significant correlations between sex and both perceived conflict and outcomes. Moreover, age was found not significantly related to perceived conflict variables while it related positively to perceived Depression and Somatization. Concerning employment characteristics, neither Working Seniority nor Night shifts related to the study variables. In addition, all perceived conflict variables and outcomes were positively correlated.

Descriptive analyses were also applied to explore frequencies and percentages of nurses' perceived levels of stress related to conflictual relationships and self-reported diseases. Data showed the relevant presence of perceived high levels of Conflict with Physicians (56.9%, $N=114$), with Peers (56.9%, $N=114$) and with Patients and their families (53.8%, $N=108$). Moreover, 46.8% ($N=94$) perceived Problems with Supervisors and 38.5% ($N=77$) reported high levels of perceived Discrimination. With respect to health conditions, data showed that 64.9% ($N=130$) of nurses scored at high levels for Somatization, 58.8% ($N=118$) Interpersonal-Sensitivity, 58% Hostility ($N=116$), 55.6% Depression ($N=111$) and 46% Anxiety ($N=92$).

Testing the effects of perceived levels of conflict on nurses' health conditions

Table 2 showed the effects of Conflict with Physicians, Problems with Peers, Supervisors, Patients and their families, and Discrimination on high levels of Anxiety, Depression, Somatization, Hostility and Interpersonal-Sensitivity. Logistic Regression Analysis demonstrates that Conflict with Physicians, Problems with Supervisors, Patients and their Families were all significantly associated with poor mental health. In particular, Conflict with physicians resulted in the higher risk of Somatization (OR=14.85, CI=4.07-54.16), Depression (OR=10.87, CI=3.41-34.67) and Interpersonal-Sensitivity (OR=8.10, CI=2.63-24.86). Problems with patients and their families predicted the highest Anxiety (OR=6.90, CI=3.41-34.67) and Hostility (OR=7.87, CI=2.59-23.89) odds ratios. Perceived Discrimination was associated with high levels of Somatization (OR=4.29,

CI=1.24-14.80), Depression (OR=3.14, CI= 1.07-9.18) and Interpersonal-Sensitivity (OR=2.87, CI=1.00-8.20). No findings supported the association of Problems with peers with outcomes.

Conclusions

The first aim of the present study was to investigate perceived levels of stress related to conflictual relationships and psychological and interpersonal diseases among nurses.

Considering correlation analyses, our data showed that male and female nurses showed no significant differences concerning perceived levels of conflict as well as outcomes. In this perspective, our results are not consistent with previous literature which supported that male nurses were significantly at higher risk of experiencing violence and conflict (Pai and Lee, 2011; Piquero *et al.*, 2013; Wei *et al.*, 2016) and with studies which highlighted that females were at higher risk of reporting poor mental health (Hankin and Abramson 2001; Denton, 2004; Pinguart and Soresan, 2006). Moreover, our data showed that older nurses were more likely to report Depression and Somatization, when compared with younger nurses, but there were no age differences for levels of conflict, Anxiety, Interpersonal-Sensitivity and Hostility. Nevertheless, in previous research, younger workers were at a higher risk for experiencing higher violence and conflict in workplaces (Pai and Lee, 2011; Piquero *et al.*, 2013; Wei *et al.*, 2016) and older workers reported higher well-being (Cavalheiro *et al.*, 2008; Schreuder *et al.*, 2010; Najimi, 2012; Rashedi 2014).

Concerning perceived levels of stress related to conflictual relationships, our data also suggest the foremost presence of perceived Conflict with Physicians (56.9%) and Problem with Peers (56.9%), followed by Patients and their families (53.8%). These results seem to be a characteristic feature of our healthcare context; indeed literature underlined Patients and their families as the main source of conflict reported (e.g. Gillespie, 2010; Pai and Lee, 2011; Piquero *et al.*, 2013).

The second purpose of our study was to evaluate effects of perceived levels of stress related to conflictual relationships on psychological and interpersonal health conditions. Logistic Regression Analysis showed significant associations of specific sources of pressure with higher likelihoods for reporting diseases. In particular, Conflict with Physicians resulted in higher risk of Somatization, Depression and Interpersonal-Sensitivity, while conflict with Patients and their families predicted the highest Anxiety and Hostility odds ratios. Moreover, in line with the major results associated with Conflict with Physicians, perceived Discrimination was significantly associated with higher levels of Somatization, Depression and Interpersonal-Sensitivity. Therefore, our data supported the risk of a spiral of conflict and violence, extremely harmful for nurses' well-being. Indeed, a conflictual relation with physicians may be associated with increasing frustration, poor mental health and interpersonal-sensitivity among nurses (i.e. negative expectations concerning relationships, perceived low esteem from others, low self-evaluation, sense of inferiority), exacerbating negative interactions and the risk of diseases. Otherwise, inappropriate patients' demands and their aggressive behaviours may raise communication gaps, which in turn exacerbate hostility and anxiety levels, affecting the sense of safety and security at workplace.

In summary, helping and improving a virtuous relational approach, in particular involving physicians, patients, and their families, should be considered one of the main purposes in defining interventions, in order to interrupt the conflictual vicious circle and promote nurses' well-being.

Acknowledgements

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TABLE 1 Descriptive Statistics and Person's correlations between the study variables (N= 200)

	M	SD	1	2	3	4	5	6	7	8	9	10	11	12	13
1 Sex ¹	1.5	.49													
2 Age	45.9	10.0	-.11												
3 Working Seniority ²	1.8	.32	-.05.74**												
4 Night Shifts ³	1.7	.44	-.09.26**	.34**											
5 Conflict with physicians	8.5	4.8	-.01.11	-.01	.04										
6 Problems with supervisors	12.5	6.7	-.03.03	-.08	-.07	.53**									
7 Patients and their families	16.9	8.2	.01.10	-.04	-.02	.80**	.61**								
8 Problems with peers	7.3	5.1	.01.08	-.07	-.07	.65**	.37**	.52**							
9 Discrimination	3.8	4.2	-.03.05	-.02	-.01	.62**	.30**	.41**	.50**						
10 Anxiety	.54	.71	-.03.14	.09	.03	.34**	.31**	.40**	.41**	.21**					
11 Depression	.65	.64	-.01.15*	.07	-.01	.33**	.21**	.36**	.40**	.28**	.85**				
12 Somatization	.79	.69	-.02.14*	.09	.07	.39**	.37**	.46**	.35**	.23**	.85**	.72**			
13 Interpersonal-Sensitivity	.58	.74	-.01.13	.06	-.03	.27**	.13	.27**	.40**	.30**	.78**	.90**	.58**		
14 Hostility	.54	.73	-.02.05	.01	.01	.23**	.30**	.35**	.24**	.16**	.74**	.80**	.58**	.72**	

¹1= male; 2= female. ²1 < 7 years; 2 > 7 years. ³1 = no; 2 = yes
*p < .05; **p < .01

TABLE 2 Odds-ratio for health outcomes according to Conflict with physicians, Problems with supervisors, Problems with patients and their families, Problems with peers and Discrimination in nurses workers

	Anxiety		Depression		Somati- zation		Interpersonal Sensitivity		Hostility	
	OR	C.I.	OR	C.I.	OR	C.I.	OR	C.I.	OR	C.I.
Conflict with physicians	6.52**	2.17-19.60	10.87**	3.41-34.67	14.85**	4.07-54.16	8.10**	2.63-24.86	5.70*	1.94-16.69
Problems with supervisors	5.33*	1.74-16.30	7.66**	2.46-23.84	2.46*	1.08-7.24	3.00*	1.08-8.29	4.12*	1.43-11.84
Problems with patients and their families	6.90**	2.27-21.01	5.77**	1.97-16.16	5.85**	1.02-33.35	4.36*	1.53-12.36	7.87**	2.59-23.89
Problems with peers	2.32	.880-7.59	2.44	.789-6.74	2.09	.738-6.75	1.95	.723-5.29	1.46	.545-3.94
Discrimination	1.73	.611-4.94	3.14*	1.07-9.18	4.29*	1.24-14.80	2.87*	1.00-8.20	2.34	.826-6.67

* < .05; ** < .0.01

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Learning objectives

Participants will...

1. learn specific sources of conflict, aggression and violence and the their different perceived weight in nursing profession.
2. identify effects of sources of stress related to conflict in healthcare context on psychological health conditions in nurses as well as on quality of healthcare relationships. The risk of a vicious circle will be described.

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Providing second victim support to healthcare workers who experience the psychological impacts of stressful events including acts of aggression/violence in the workplace

Sub-theme: Emotional/Psychological impacts of aggression/violence

Poster

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Keywords: Second Victim Support, Institutional Support, Psychological First Aid, Psychological impact of aggression/violence

Background

Healthcare workers frequently experience stressful events including acts of violence and aggression, but there has traditionally been little institutional support to help them cope with the associated distress. A peer-support program called RISE (Resilience In Stressful Events) is designed to help hospital staff cope with stressful patient-related events, which includes acts of aggression towards the healthcare worker. This program aims to provide multidisciplinary, peer to peer support in a nonjudgmental environment with an aim of providing timely support and help to healthcare providers. The responder engages the team member to employ healthy coping strategies to promote overall well-being. By helping healthcare workers cope more effectively after stressful events, such as acts of aggression or violence, they are less likely to leave their profession and/or lose productive time at work due to psychological trauma, which has been associated with aggressive events. When they do confide in others, most choose colleagues and supervisors. Given a choice, many would prefer to receive support from a trusted colleague with intimate knowledge of their work environment and its challenges. An ideal colleague-confidant is one who's familiar with the victim's specific professional role. Such colleagues, especially those who've been second victims themselves, can offer powerful healing words and support.

Methodology

The RISE program encompasses a team of providers who share call responsibilities to respond to stressful events throughout the hospital. The team is trained in psychological first aid, and receives annually ongoing training to meet the ever changing needs of a large academic medical center. When a stressful event occurs either a team member or supervisor can call the RISE team. A responder returns the call within 1 hour and generally sets up a meeting time within the first 24 hours following the call. It is of note, that the events is deemed stressful by the caller. The response is the same regardless of the event type, the goal of the provider is to establish initial contact, setup a meeting team and then meet with the individual or group, to offer psychological support. We also offer resources for continued individual psychological needs.

Findings

The RISE team has been an active group for the past 5 years and has responded to over 100 calls, about 5-10% of these calls have been linked to aggression and violence. In many of these cases, a group response was needed. While we do not yet have quantitative data to indicate a positive experience the group does have several qualitative statements from 2nd victims indicating that the interactions with the RISE team was beneficial. In addition, many of our referrals are from departments that have used RISE in the past.

Implications

Peer support programs for second victims have made a significant difference on healthcare workers ability to cope and continue to provide high quality, safe patient care after a stressful, patient-related event. Providing timely peer support to healthcare workers who have been the victim of aggression or violence while caring for their patient.

Learning objectives

Participants will...

1. be able to describe and understand the RISE peer support program.
2. be able to explain how the benefits to health workers who have experiences acts of violence/aggression at work.

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The relationship between inexpressive aggression and depression in Japanese male prison inmates

Sub-theme: Emotional/Psychological impacts of aggression/violence

Poster

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Keywords: Inexpressive aggression, depression, emotion regulation, prison inmates

Abstract

Researchers on aggression distinguish two types of aggression, reactive and proactive (Crick & Dodge, 1996; Dodge & Coie, 1987). Recently, Yamasaki and Nishida (2009) suggested subtypes of reactive aggression: reactive-expressive (overt aggression) and reactive-inexpressive (covert hostility). They found that reactive-inexpressive aggression elicits depression. In a study with Japanese students, further, we analyzed emotion regulation involved in inexpressive aggression and found that inhibition or control of aggression generates other negative mental state than anger, that is, depression (Kawabata & Ohbuchi, 2014). Therefore, we predicted that hostility and anger increase depression. Gross (1998) proposed two types of emotion regulation: reappraisal and suppression. Reappraisal reduces both the expression of negative emotions and the impact of the subjective emotion experiences, whereas suppression reduces only the expression of negative emotions, but does not reduce the impact of it. Thus, we predicted that reappraisal decreases depression, whereas suppression increases depression. The hypotheses in this study were (1) hostility will increase depression, (2) anger will increase depression, and (3) reappraisal of anger situations will decrease depression, and (4) suppression of anger will increase depression in the circumstances where aggression is strictly inhibited.

In this study, 379 Japanese male prison inmates responded to a Japanese version of questionnaire battery that consists of Buss-Perry Aggression Questionnaire (BAQ) (Buss & Perry, 1992; Ando *et al.*, 1999), Emotion Regulation Questionnaire (ERQ) (Gross & John, 2003; Yoshizu, Sekiguchi, & Amamiya, 2013), Kessler 6 (K6) (Kessler *et al.*, 2003; Furukawa, *et al.* 2008), and Balanced inventory of Desirable Responding (BIDR) (Paulhus, 1991; Tani, 2008). Hostility was measured by the hostility subscale of and anger was measured by the anger subscale of BAQ. As emotion variable, two types of emotion regulation were measured by ERQ. Depression was measured by the total score of K6. Because participants of the study were prison inmates, we measured a tendency of socially desirable response to control it in the analysis.

We conducted SEM to test the hypotheses. The results partially supported the hypotheses. Consistent with Hypothesis (1) and (2), hostility and anger increased depression. Hypothesis (3) and (4) was not supported. Suppression decreased depression by way of hostility and anger. Reappraisal increased depression by way of anger. We interpreted that a decrease of depression by suppression might have been caused by a chronic use of suppression. That is, a chronic use of suppression might generate goal disengagement (to withdraw effort and commitment from an unattainable goal), and it was demonstrated that goal disengagement was associated with high subjective well-being (Wrosch, Scheier, Miller, Schulz & Carver, 2003). We also interpreted that reappraisal in which participants rethought or reconsidered social conflict situations from different perspectives might have caused ruminations of anger, which increased depression.

Learning objectives

Participants will...

1. understand the relationship between inhibition or control go aggression and depression.
2. learn the risk to increase depression when they treat aggressive patients in the circumstances where aggression is strictly inhibited.

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Resilience at work: A longitudinal investigation of the impact of perceived organizational support, aggression management training, sex, and acute stress disorder symptoms on emotional well-being

Sub-theme: Emotional/Psychological impacts of aggression/violence

Poster

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Keywords: Patient aggression, perceived organization support, acute stress disorder, emotional well-being, aggression management training

Abstract

Healthcare workers, and especially those in psychiatric care, frequently witness and experience patient assaults and threats in the context of their work. Most studies on the subject have shown that patient aggression can have a deep and profoundly negative impact on workers' mental and physical health. In light of this growing evidence, researchers have for long urged organizations to enact effective violence prevention strategies. Obviously, no organization can completely eliminate all instances of patient aggression, but what happens when a real and concrete effort is put into place to combat this social problem?

This study looks at the evolution of emotional wellbeing in a sample of 81 Canadian healthcare workers over the course of one year (35 males/46 females) who experienced an act of patient aggression (i.e. serious threats or physical violence) either directly or indirectly (i.e. witness or target). Measurements were taken at four different time points over the course of a year following (less than two weeks, 8 weeks, 24 weeks, and 52 weeks).

Descriptive statistics suggest that patient aggression is a relatively common phenomenon for these workers who reported on average 5.6 physical assaults in the last year. Yet levels of general well-being were relatively high and stable throughout the year as was perceived organizational support. Nearly half of the sample had received aggression management training. The presence of acute stress disorder symptoms was also significant at T1 ($M=37$, $SD=16.17$) with approximately 15% of the workers meeting the diagnosis cut off score for ASD. Individual growth curve analysis was used to map out trajectories of well-being over time. Model selection was guided by information criteria (BIC, CAIC, AIC).

The final model suggests that levels of wellbeing did in fact remain high ($I=105.62$, $SE=6.15$, $t=17.16$, $p<.000$) and relatively stable over time ($S=-.17$, $SE=.08$, $t=-2.063$, $p<.043$). People who perceived higher levels of organizational support ($S=.31$, $SE=.12$, $t=2.66$, $p<.009$) and had lower levels of ASD symptoms ($I=-.58$, $SE=.09$, $t=-6.36$, $p<.000$ | $S=.01$, $SE=.002$, $t=3.505$, $p<.000$) also reported higher levels of well-being. Interestingly, men and people who have received training appear to be happier although not significantly so.

Previous victimization, levels of confidence dealing with patient aggression and positive and negative social support from loved ones did not relate significantly to well-being and had to be removed to improve model fit. In a way, the findings underline the resilience of healthcare workers in the context of patient aggression and the relevance of perceived organizational support as a protective factor. On the other hand, the predictive power of ASD on both intercept and slope reminds researchers and managers of the importance of routinely assessing trauma symptoms in workers exposed to aggression.

Learning objectives

Participants will...

1. be able to open up a dialogue on solutions to coping with patient aggression.
2. be able to reflect on the best analytical strategies to capture the complexities of patient aggression.

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Effect of harassment and aggression on work performance of Lady Health Workers in rural Sindh, Pakistan

Sub-theme: Service related impacts of aggression/violence

Poster

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Keywords: Harassment, bullying, Lady Health Worker,

Background

The Lady Health Workers (LHWs) of Pakistan's National Program for Family Planning and Primary Health Care (NP for FP and PHC) are required to provide community based basic health education and primary health care to households in rural communities. Each of the LHWs is mandated with two hundred households of her catchment population and is required to make house visits on a routine basis. A qualitative study was conducted to identify psychological and social factors affecting mental health and work performance of Lady health workers (LHWs) working in a rural areas of Sindh, Pakistan.

Methodology

Focus Group Discussions and In-depth Interviews were conducted with lady health workers and their supervisors in district Tando Muhammad Khan in Sindh. Factors affecting work performance of Lady Health Workers (LHWs) were explored using qualitative methods. Thematic content analysis techniques were then used to analyze data collected and develop results.

Results and conclusion

Study results revealed that as a woman required to move alone in rural areas, the consequences LHWs faced include threats from community members, violence and harassments from the society. Participants shared that many times they are harassed by the men in their catchment population, especially during polio campaigns. This ranged from verbal abuse to attempted physical threats. But when complaints were made to concerned officials, they were asked to remain quiet because authorities feared that if any action was taken against the identified people who harassed LHWs, they will start refusing for polio drops to their children, thereby affecting coverage. The supervisors confirmed harassment as a problem for the female health workers but due to lack of any policy for such issues, they were unable to provide any relief to the affected workers.

Moving around in the community was identified as a significant problem for young and unmarried health workers. They are faced with problem of completing their assigned tasks while negotiating her way around the issues of harassment, flirtations and abuse by the younger male members within the catchment area.

Majority of LHWs are also faced with the threat of physical abuse and were forced to use an Abbaya as a protective shield to cover themselves completely, especially when working in overcrowded market places. The LHWs have to exercise caution when going to household with different religious and cultural practices than their own. Bullying, vulgar comments, uninvited physical contact, all these issues were identified as part of their daily routine. Sometimes, the LHWs were also faced with defending themselves from stray dogs. In case of a dog bite, participants shared that, no steps were taken to provide them with protection nor was any medical help provided by the district authorities.

All these factors lead to stress and depression, hence affecting their work performance for delivery of basic health care to the rural population, especially women and children.

Learning objectives

Participants will...

1. be able to appreciate the extent of violence community health workers are exposed to in developing countries.
2. be able to understand the circumstances leading to vulnerability of the community based health workers in developing countries.

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Distress, suffering or violence during childbirth: current reflections and practices of community outreach workers

Sub-theme: Service related impacts of aggression/violence

Paper

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Keywords: Collaborative research, Violence or distress during childbirth, Healthcare settings, Perinatal workers' practices.

Abstract

The issue of violence during childbirth has been taking up more and more importance in the demands of women's rights groups locally and worldwide. In Québec, one of the community perinatal groups putting forward this issue is the Regroupement Naissance-Renaissance, which comprises community outreach workers as members. These community outreach workers are often left feeling helpless when confronted with the distress/suffering/violence phenomenon experienced by women during childbirth. They have indeed expressed a need to acquire additional knowledge regarding this phenomenon and to be informed of the best practices.

In order to better support these workers and to start a common reflection on this emerging issue, this presentation will identify the perceptions of community outreach workers on the phenomenon of distress/suffering/violence during childbirth. Results from focus groups among community outreach workers working in perinatal care performed as part of a collaborative research will be discussed during this presentation. The results are structured along these themes: perinatal workers' perceptions of the distress/suffering/violence phenomenon at perinatal stage illustrated by real-life observations, the problems workers face when confronted with the phenomenon, and workers' current practices. These results lead to a better understanding of the reality of community outreach workers facing this issue and of the practices they have put in place to deal with it. They also lead to a reflection on the most optimal strategic actions to prioritize at women's and couples' level, as well as at collective and institutional levels.

Learning objectives

Participants will...

1. have an better understanding about experience of distress, suffering or violence of women during childbirth.
2. reflect about actions to prioritize with women and couples, as well in healthcare settings.

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Restraining abusive practice: Practising inside a legal, moral and ethical code

Sub-theme: Professional, legal and ethical impacts of aggression/violence

Workshop

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Keywords: Physical restraint, Legal, Moral, Ethics, Abuse

Abstract

While safeguarding is an international issue, recent scandals in care settings in the United Kingdom have raised major public concern. Undercover filming within care settings found abusive practices, with illegal and abusive restraint being a significant feature. Between 2010 and 2013, 662 non-natural deaths were reported among those detailed due to mental illness (EHRC 2015). Likewise, from 2011-2012 Mind reported 3,439 service users in the United Kingdom had been restrained in the prone position, a position now discouraged. The impact of such scandals can lead to a tendency for practitioners to adopt defensive practice, thus reducing opportunity for positive risk taking, the latter playing a central role in assisting personal development and enhancing a person's quality of life. Legislation and policy, such as The Mental Capacity Act (MCA) (2005), the Deprivation of Liberty Safeguards (Ministry of Justice 2008) for people who need to be deprived of their liberty, and who do not have mental capacity in relation to making decisions regarding their care and treatment, and the Care Act (2014) are frameworks within which professionals in the United Kingdom are expected to practice. While the MCA (2005) can be used to restrain a person, NICE (2005) guidance regarding restraint advises account be taken of 'necessity', referring to Articles 2, 3, 5 and 8 of the European Convention on Human Rights, and the principle of 'proportionality'. Professionals are required to recognise these rights, when delivering care to vulnerable people, such as those in mental health care. However, there has been growing concern regarding abusive practices in institutions, with a number of reports identifying unacceptable methods of restraint as a feature of care. In keeping with the service user movement, this paper presents a review of the literature regarding restraint from the perspectives of service users and professionals within mental health services in the United Kingdom and considers the implications for future practice and research. In reviewing the literature findings revealed restraint is often experienced as a form of abuse, it's inappropriate use often being a consequence of fear, neglect and lack of using de-escalation techniques. Using restraint in this way can have negative implications for the well-being of service users and mental health professionals alike.

Learning objectives

Participants will...

1. gain a basic understanding of legal considerations regarding physical restraint.
2. identify factors that constitute illegal and abusive restraint.

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Safety first, but whose safety? Public Health verses Occupational Health in situation of conflict

Sub-theme: Professional, legal and ethical impacts of aggression/violence

Paper

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Keywords: Public Health, Occupational Health, Polio Workers, Pakistan

Abstract

Providing high-quality health care should not be hazardous to the health worker therefore the concept of Occupational Health Safety is becoming prime concern especially for Healthcare workers. Many frontline health workers face a wide range of occupational safety and health hazard including physical, biological, chemical, psycho-social and gender-based violence and discrimination. It is argued regarding the amount acceptable level risk that healthcare workers put on themselves in order to perform their job especially while providing healthcare to communities in a conflict zone. Recently in Pakistan, polio workers have been targeted that has resulted in verbal threat, kidnapping, injuries and more significantly to killing or loss of life of Healthcare workers. The militants has their justified reason for this act that is basically the result of huge mistrust on public health intervention because of fake hepatitis vaccination program that was run by CIA and used Pakistani doctor to obtain DNA from Osama bin Laden's suspected hideout.

The focus of public health intervention is on improving quality of life of population whereas, occupational safety emphasis greater concern on safety of healthcare worker because if healthcare workers are not protected than wellness of society cannot be assured.

This article illustrates the tension that exists between occupational safety and public health measures in the situation of conflict. Developing counties are already facing healthcare workforce shortage and saving lives should not be accomplished by sacrificing provider's own lives. Millennium Development Goals for health cannot be achieved without healthy, well-prepared, motivated healthcare workers that can only be done by ensuring their occupational health safety.

Learning objectives

Participants will...

1. understand scope of the problem.
2. understand the overlap between public health and occupational health safety.

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The killing of prisoners of conscience in China for their organs

Sub-theme: Professional, legal and ethical impacts of aggression/violence

Paper

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Keywords: Organ transplant abuse, ethics, policy, law

Background

The Government of China acknowledges that prisoners have been for years the primary source of organs for transplants. There is substantial evidence that many of these prisoners have been prisoners of conscience, in particular, practitioners of the spiritually based exercises Falun Gong, a Chinese equivalent of yoga.

Methodology

There has been substantial research, starting from 2006, into the killing of prisoners of conscience in China for their organs. The present study attempts to bring this research up to date by looking at data from individual transplant hospitals in China. Hospital websites, newsletters, news stories, research publications and any other information emanating from individual hospitals is used to obtain aggregate data.

Findings

The key finding of this work is that the volume of transplants in China is substantially larger than previously indicated. The Government of China has given out total transplant volumes per year which already places China as the country with the highest transplant volume world wide after the United States. This research concludes that the official Chinese total transplant volumes are a substantial under-estimation. The research further analyzes the potential sourcing for this large volume, in light of the limitation on sourcing from prisoners sentenced to death, the absence for much of the period under study of a donation system for organs and the ineffectiveness of the donation system eventually established, the absence for much of the period under study of a national organ distribution system, the prohibition both legal and cultural against sourcing organs from accident victims - the brain dead, cardiac alive, and the presence of a huge organ donor pool of prisoners of conscience. The conclusion is that the bulk of organs in China comes from this source, prisoners of conscience, killed for their organs.

Implications

China has been a global centre for transplant tourism. One reason has been the absence of precautions to prevent that sort of tourism. One implication of this study is the need world wide to put in place precautions to prevent organ transplant abuse from happening. Those precautions would include compulsory reporting by the health profession of transplant tourism, barring entry to any country of those foreigners complicit in organ transplant abuse, denial of public health care funding for transplant tourism and its after care and prosecution of those who are complicit in the killing of innocents for their organs.

A second implication is the need for the global health profession to avoid complicity in this abuse. That would mean preventing presentation of research, whether at conferences or in journals, based on organ transplant abuse. It would also mean denial of organ transplant training to those who would use that training to engage in organ transplant abuse. It would mean further not attending any transplant meetings in China or elsewhere which allow for presentation of research based on organ transplant abuse.

Learning objectives

Participants will...

1. come to appreciate the scale and manner of organ transplant abuse in China.
2. learn what they can do to avoid complicity with that abuse and to help to avoid the complicity of others.

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Threats and Violence in the Lead-up to Psychiatric Mechanical Restraint: A Danish Case Law Study

Sub-theme: Professional, legal and ethical impacts of aggression/violence

Poster

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Keywords: Psychiatry, Violence, Mechanical Restraint, Law

Background and context

The amount of mechanical restraint (MR) use in psychiatry causing complaints and subsequent legal disapprobation from the authorities is increasing in Denmark. Regarding MR in general, literature points out great variations in rates, frequency, indications, and duration among countries but with an increasing trend. Correspondingly in Denmark, even if it is acknowledged that MR should only be utilized short-term and in due proportion to the benefits and risk entailed, its use has increased. As MR, like other coercive measures, can represent a momentous insult from a patient's view and could collide with bioethical patient autonomy principles as well as health law informed consent obligations this is problematic.

A reduction in usage is considered warranted and addressing illegitimate MR would be an obvious point of departure. In so far as one important reason for instigating MR is dangerous patient behavior and research has suggested that many MR episodes result from experienced violence or threat of violence by staff these aspects attract special attention. This study analyzes the role of threat, violence, and contextual characteristics in MR lawsuits.

Methodology

In Denmark a Psychiatric Complaint Board considers patients' complaints about compliance with law. The Board annually makes public a selection of case decisions. A case law review was carried out on all publicly available lawsuits concerning MR completed by the Board during the years 2007-2014 with focus on case contents like threatening behavior, violence, patient characteristics, MR type, and case decision.

Findings

Among 163 cases, 28 cases (17%) revealed physical violence towards staff or other patients (for example in one case the patient restrained a staff contact person with a choke hold thereby impairing breathing and causing neck musculature injury). Twenty-two cases (13%) implied self-destructive patient behavior. In 41 cases (25%) there had been expressed verbal threats, and 13 cases indicated physical threat (for example threatening fist towards staff). In 46 (28%) cases other violent (e.g. psychological) or aggressive behavior was described (e.g. humiliating remarks). In 52 cases (32%) there was information that belt fixation had been supplemented with arm or leg fixation. MR was concluded illegal in 124 (76%) of cases and in 33 cases (20%) the duration of MR use was concluded illegal. Among that minority of 25 cases with threatening or violent patient behavior and known patient gender, 84% (21) of patients were males. In 19 cases (12%) a psychotic or resembling condition had been noted. As regards limitations it should be noted that published case material represents only a selection of case summaries in which information is often incomplete. Dark figures presumably are widely present. Similarly, it should be mentioned that Board cases are patient-initiated and provide an incomplete picture of the occurrence of violence.

Implications and Perspectives

Knowledge about the actual role of violence and threats in MR lawsuits is crucial to inform future regulation and initiatives aiming at MR reduction whilst ensuring psychiatric ward safety.

Learning objectives

Participants will...

1. appreciate that in lawsuits concerning psychiatric mechanical restraint (MR), threatening or violent patient behavior seem to be important components.
2. appreciate that knowledge about the actual role of violence and threats in MR lawsuits is crucial to inform future regulation and initiatives aiming at MR reduction whilst ensuring psychiatric ward safety.

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Patients' perceptions of transgressive behaviour in care relationships with nurses: a qualitative study

Sub-theme: Emotional/Psychological impacts of aggression/violence

Paper

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Keywords: Aggression, general hospital, nurse–patient relationship, nurses, nursing, patient, patients' experiences, qualitative research, transgressive behaviour, violence

Background & context

Aggression and transgressive behaviour in healthcare have been a focus of research over the last decades. Most studies describe staff experiences on patient aggression. Patient' perspectives on aggression and transgressive behaviour in interactions with nurses are rarely sought. This study aimed to gain insight in the onset and meaning of transgressive behaviour in care relationships with nurses, from the perspective of patients.

Methodology

A qualitative interview study was conducted. Twenty patients were purposefully sampled from six wards of two general hospitals. Semi-structured interviews were carried out in 2011. Data were analysed using the constant comparative method influenced by the grounded theory approach.

Findings

On elaborating on what constitutes experiences of transgressive behaviour, patients employ a framework of suppositions towards hospital care and nurse–patient relationships. This framework leads to implicit ideas on how competent professional caregivers will be and on how relationships with nurses will be characterized as normal human interactions. When these anticipated ideas are not met, patients feel obliged to address this discrepancy by adjusting their expectations or behaviour. Patients become more vigilant with regard to care given by nurses; search for own solutions; make excuses for nurses or reprioritize their expectations. Because of this adjustment, perceptions of transgressive behaviour are reinforced, mitigated or put into perspective.

Implications

Patients adjust their behaviour based on what they experience in care relationships with nurses or the hospital care. It is crucial that patients feel free to discuss their assumptions or untoward needs and nurses learn to understand and reflect on those experiences. Insight in patients' perceptions of transgressive behaviour should contribute to nurses' and managers' understanding of patients' suppositions towards hospital care and care relationships and the impact of those suppositions on perceived quality of care.

Learning objectives

Participants will...

1. have an understanding of how patients experience and categorize diverse incidents of perceived transgressive behaviour in care relationships with nurses.
2. understand how patients can report satisfaction with the care they receive while there is an underlying process of being confronted and having to deal with negative experiences regarding hospital care and nurse–patient relationships.

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Chapter 5 – Minimizing violence and/or aggression

This chapter encompasses presentations on the following sub-themes of the conference:

- Creating aggression and violence minimizing cultures
- The minimization/reduction of seclusion, restraint and coercive measures

Factors Associated with Attitudes of Men towards Gender and Intimate Partner Violence Against Women in Eastern Ethiopia: A Multinomial Logistic Regression Analysis

Sub-theme: Creating aggression and violence minimizing cultures

Paper

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Keywords: Attitudes, Gender, Violence, Childhood, men

Abstract

Intimate partner violence against women can occur between people in an intimate relationship mostly in gender inequitable society. The attitudes of men towards gender and violence against women is receiving increasing attention. Thus, this study was aimed at determining the attitudes and experiences of men towards gender and violence against women in Boset Wereda, East Ethiopia.

A cross-sectional population based household survey was conducted between April, 1 and May, 15, 2015 using quantitative data collection method. Systematic random sampling was used to select a sample of 420 ever partnered men. The collected data were principally analyzed using Multinomial Logistic Regression by SPSS version 21.

Overall, childhood experience for any form of violence was witnessed by 87.6% of men. The vast majorities (98.8%) of men ever perpetrated any form of violence against their wife. Almost all (99.1%) men agreed to at least one of the gender inequitable statements and few (1.0%) agreed to non of the gender inequitable statement. Higher age of men (RRR, 2.56; 95%CI, 1.39-4.71 and RRR, 2.09; 95%CI, 1.18-3.71), higher income (RRR, 2.63; 95%CI, 1.00-6.93), witnessing childhood sexual violence (RRR, 3.03; 95%CI, 1.32-6.96 and RRR, 3.14; 95%CI, 1.45-6.82), and ever perpetrated physical intimate partner violence (RRR, 1.60; 95%CI, 1.21-7.01 and RRR, 1.56; 95%CI, 1.12-19.79 were associated with gender equitable men in both first and second trials.

High prevalence of witnessing childhood violence and ever perpetration of any form of violence against wife/partners were observed. Nearly all of the men agreed to at least one of the gender inequitable statements. Higher age and higher income, witnessing sexual violence during childhood and ever perpetrated physical violence against their wife increases the risk of having lower gender equitable men. Interventions targeting parents or guardians should be instituted, and education should target to shape children during their early.

Learning objectives

Participants will...

1. learn about the very high prevalence (87.6%) of witnessing childhood experiences of violence in the study area.
2. learn about the very high prevalence (99.1%) of men agreeing to at least one of the gender inequitable statements.

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Uncaring Nurses: Surviving Academia

Sub-theme: Creating aggression and violence minimizing cultures

Paper

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Keywords: Violence, power, competitive, elitism, hierarchy, nursing, academia

Introduction

Incidents of workplace violence, including faculty to faculty violence, are common in academic settings (Keim & McDermott, 2010). Horizontal violence develops in part as a result of relationships distinguished through imbalances of power (de Wet, 2011; Sebok & Chavez Rudolph, 2010). In academia, exertions of power can be expected, encouraged, rewarded, and justified in the quest for tenure and promotion (Twale & De Luca, 2008). This may result in power imbalances that foster and promote mistreatment within academic settings (Hearn, 2003; Sebok & Chavez Rudolph, 2010), including within nursing academia, negatively impacting faculty, staff and students (Clark & Ahten, 2012; Luparell, 2011; Marchiondo, Marchiondo & Lasiter, 2010; Robertson, 2012). The psychological and societal consequences of violence in nursing academia are harmful to faculty and students, and ultimately result in negative consequences for nursing as a profession. Violence in nursing academia has often been explored from the perspective of incivility by students towards faculty as well as faculty towards students (Altmiller, 2012; Clark & Kenaley, 2011; Dalpezzo & Jett, 2010; Del Prato, 2013; Kolanko *et al.* 2006; Lassiter, Marchiondo & Marchiondo, 2012; Mott, 2014), however very little attention has been paid to faculty to faculty violence. To address the prevalence of workplace violence in nursing, a review of the culture of nursing academia and education was conducted. Recognizing the shortages being experienced within nursing and nursing academia, it is imperative that violence in nursing academia be addressed and coping mechanisms for faculty be identified.

Methodology

This paper summarizes selected results from a Canadian doctoral study. The purpose of the study was to increase understanding of faculty to faculty violence in nursing academia. Utilizing a theoretical framework incorporating the perspectives of Mason (2002) and Foucault (1995) and focussing on the concepts of violence, power, knowledge, differences and resistance, the study explored aspects of the social and cultural work environment, and organizational policies and procedures influencing workplace violence between faculty members. Using principles from critical ethnography, the research was conducted within three schools of nursing at universities located in one province in Canada. Data collection included 29 semi-structured interviews with nursing faculty, support staff and managers, and mute documents such as internal policies.

Findings

The findings confirmed that nursing academia is a violent environment. Uncaring practices were identified, including competitiveness, being critical, stratification, public and hidden hostility, control, oppression, stigmatization, intimidation, and silencing. The consequences of the violence experienced included normalization of behavior, suffering and uncertainty. Feeling disrespected and discounted was prevalent, and arose from differences including differences in rank, educational preparedness and teaching and research philosophies, including research focus and methodology, to name a few. These differences resulted in the development of tensions within the school.

I think that's when you get some of those status differences. It's not a person to person bullying but it's a putting down of a class of faculty... So I think you get those status differences, which creates some tensions. (Frankie)

Faculty developed and utilized a variety of survival strategies in order to manage within this academic environment. Various coping mechanisms were identified by participants, and these included both personal and professional work life strategies. Evidence also emerged indicating that schools of nursing were beginning to identify a need to change the competitive, elitist and hierarchical environment. Efforts towards transformation being undertaken in some schools of nursing are noteworthy. These results are now presented.

“An Extraordinary Career”

Academia is a demanding profession. Significant time and effort is required to be successful, and as a result participants spoke at length about the many sacrifices required. Academics were described in this study as being dedicated, hardworking and type A personalities commonly working very long hours to attain success. As a result, academia was described as a unique profession, one unable to support and sustain complicated personal lives. The challenges placed on female academics were described, with participants being aware of the increased pressure and demands placed on them as a result of their gender. Academia was described by one participant as an “*extraordinary*” career that did not allow for personal “*entanglements*”. Another participant identified that as a woman, you could become too easily distracted by family and personal issues and concerns, potentially negatively impacting the time available for academic pursuits.

The person told me I had to stop having babies after two. I thought that was interesting but it was just said in a matter of fact way. And it was just, this is the way things were done here.... Like there's a part of what she was saying, it's very difficult in this world and you can't have too many [children] because it's going to be very hard to have a solid research career. (Daryl)

Participants in this study reported they had made decisions to limit the number of children they had, or to not have children altogether. They also extricated themselves from complicated relationships. These decisions were made due to the demands on their time that academia required, and resulted from their values and beliefs in the importance and significance of their work. There was a pervasive belief that academia was a special career that required absolute and complete devotion.

This is a kind of an extraordinary career where you can't have those kinds of entanglements. And... you're a woman, you're too easily embroiled in these family conflicts and I think gender plays a huge role in this, major role. And the tenure process, the promotion process is not that easy, it's a killer. And you can't have these extra demands on your time. (Brook)

“Sense of Rank”

Building a research portfolio, achieving tenure, being granted a research chair, etc. all require significant drive and effort. Unfortunately, the efforts of part time, and non-tenured faculty were not always respected, and with a higher value placed on one class of faculty, feelings of mistrust, disrespect and violation resulted.

It's so endemic in academia..... this sense of rank. And the way that we actively marginalize people based on rank. Even the title....the ones with rank get to be protected. It's a very destructive model. And I think that's where the source of much of the aggression is. (Billie)

Participants identified that when one group believed they were superior, and when they held greater power and prestige within the school, negative behavior towards colleagues resulted, damaging interpersonal relationships. “There’s a bit of an academic rank thing that goes on and I think there are a couple of people on faculty who tend to pull that. And it’s almost passive aggressive and sometimes not so passive.” (Jordan)

Making Choices

As the research intensity of the university increased, the adoption of the belief that academia is an extraordinary career requiring sacrifice became more explicit. Participants identified an inability to sustain a career in academia if one had too many outside responsibilities, and they were forced to choose between family and academia, part time versus full time, tenure versus non-tenure stream etc.

Participants who resisted the prevailing discourse and who chose to work part time, picking family over career, identified that they were not taken as seriously by their colleagues. One participant explained that while she made the decision to have a family and work part time. she modified how she presented herself to her colleagues so not to impact those relationships. She felt that if they were aware that her personal life was as satisfying as it was, it would have a negative impact on the way she would be treated. As a result, she was careful to modify her behavior to ensure that she never appeared “*too happy*”.

I don't talk about my relationship with my husband and if I have an opportunity, I always try to convey that sometimes it can be also problematic and it's not. I feel that if I enforce the idea of the fairy tale, gets worse, then I will capture lots or I will receive lots of aggressive ... I cannot be happy. I need to have problems in their eyes. It can create some issues for me in the group that sees me too happy and start to create some obstacles. It is [a strategy], yes. And a very conscious one....Very deliberate. (Jesse)

Building Relationships

Participants expressed that individuals will think twice before hurting someone they care about, and when they are hurt by someone they care about, they will be much more forgiving. Relationship building may contribute to softening and diminishing feelings of violation, reducing or eliminating the resultant perception of violence. "I think your way less fine until you're connected" (Ellen). Overall, most participants identified that nurturing relationships was very important in improving the work environment and was an important coping mechanism.

Getting to know people in a different level is important for developing better working relationships. That's my philosophy. So I think you get to know each other as human beings, you give them a little more slack, you put up with it a bit more if you know them. So I think that's incredibly important for a better culture. (Daryl).

Participants recommended that their schools of nursing create environments that supported positive interpersonal relationships and respectful workplaces for all members of the community. Evidence of the importance of this was demonstrated throughout this study. Support from managers, senior faculty and colleagues were identified as being vital for participants in surviving and thriving in academia.

Discussion

Academia in general, not just nursing academia, has been identified as a very competitive and elitist environment. Academics experience violence in their interactions with each other, and through the spoken and unspoken rules and regulations in existence. DalPezzo and Jett (2010) found that faculty to faculty violence can occur anytime there is real or perceived imbalance of power and they identified that when one group of individuals has greater prestige, power or status, feelings of inferiority within the other group can be perpetuated. Schools of nursing would benefit by promoting inclusion and equality for all employees, ensuring that all are provided with opportunities for personal and professional growth (Hornstein, 2003). These changes may assist in fostering the kind of energetic and positive work environments that are required for the promotion of excellence in teaching and scholarship (Heinrich, 2010).

Work life balance is a significant issue in academia. Glass (2003) identified what she termed was a disease of nursing academia associated with overtime and competing priorities. It has been previously noted in the literature that female academics are considerably less likely to have children than are male academics (Gill, 2009). Participants in this study reported being given advice about limiting the number of children to have, and terminating relationships which were too demanding on their time. It has been noted in the literature that academia is an area where few women are in senior leadership positions, and where women are less likely to be tenured (Morrissette, 2011). Hearn (2003) identified that men still dominate in management, and that organizational factors such as cultural and gender based exclusionary practices are seen in academia.

Participants identified the need to keep their heads down, which was previously identified in the literature as a coping mechanism (Goldberg, Beitz, Wieland & Levine, 2013). The need to be viewed as an insider sharing the dominant values, and the need to monitor behaviors such as when to speak up and when to remain silent was discussed. Although there were some examples of resistance in the form of faculty leaving to work at other universities, the majority chose to remain in an abusive work environment. Glass (2003) identified patterns of interpersonal behaviors likened to domestic violence. The acceptance of an environment which requires one to hide and sanction words and behaviors in order to survive connects strongly with Glass' findings. Faculty may choose to accept the discourse and modify their behavior to conform and be rewarded, or they may choose to reject and resist the dominant discourse. Both of these very different responses to the same issue are examples of survival techniques. However, by accepting the prevailing discourse, and choosing to work part time, to have a family, to stop seeking tenure, faculty are contributing to the maintenance of the discourse supporting nursing academia as this extraordinary career which does not allow for personal entanglements.

The significant workload concerns identified in this study are not unique to nursing academia. Several scholars have expressed similar concerns related to these issues in academia in general (Gill, 2009; Hearn, 2003; Sparkes, 2007). Workload should be addressed at the organizational level, and the physical and emotional wellbeing of employees need become a priority (Glass, 2003). Systems which support collaboration and maintenance of quality of life need be identified and developed. Nurse academics should be able to take time away and have relationships outside of academia and still be able to fulfill the requirements for tenure and achieve success.

As competition for research grants increased, the need for successful collaboration has become more and more imperative for faculty's success. Relationship building is important and may help to shift academic norms away from competition towards cooperation. Unfortunately, workload demands leave little time for team building activities which would support the development of greater alliances. Addressing unrealistic workloads and addressing the rigid, unrealistic demands for students and faculty are recommended. Reasonable workloads and promotion of workplace balance may support relationship building, improve communication and respect.

Conclusion

Data collected by the Canadian Nurses Association and the Canadian Association of Schools of Nursing (2012) have highlighted a looming nursing faculty shortage. There is a recognized need for the recruitment of nursing faculty in Canada. Promotion of a culture which embraces diversity and promotes supportive environments, one in which scholarship is collaborative, students are involved, and successes are celebrated collectively may assist in this regard. Embracing different approaches to teaching and research may support creation of environments which accept individual preferences and differences in philosophy. Respectful behavior ought to be an expectation, and unacceptable behaviors should not be tolerated.

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Learning objectives

Participants will be able to...

1. Describe the nature of workplace violence in academia.
2. Describe the personal and professional coping mechanisms adopted by nursing faculty to manage violence in nursing academia.

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The NOW-Model

Sub-theme: Creating aggression and violence minimizing cultures

Poster

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Keywords: Aggression management, environmental factors, interaction, personal factors, problem solving, sense of security and equilibrium

Introduction

Six years ago the NOW-Model was presented for the first time at the second International Conference on Workplace Violence in the Health Sector in Amsterdam 2010. To to date a lot of discussions took place searching for applicability and for flaws of the model. Finally it became the guiding framework for the first comprehensive book published for the German speaking countries in 2012 (Walter, Nau, & Oud, 2012). The NOW-Model in its current state provides a theory integrating overview of the process from the emergence up to the (preliminary) end of an aggressive episode. Its well referenced elements provide transparency, enable to study details and foster discussion as well. The model and its references are described in English elsewhere (Nau, Oud, & Walter, 2010, 2011). To sum up in short: the NOW-model offers a comprehensive description of occurrence, contributions and trajectories of aggressive situations in healthcare. It highlights personal factors of patient/visitor and staff; environmental factors; and the interactional course between staff, clients, environment as well as organizational aspects including the supporting theories. Aggressive behaviour in this context should be seen as an attempt to communicate. It is an interactive encounter of persons (member of staff and client/patient and/or relative/visitor) within a particular environment. Both are contributing personal factors which may promote aggression or may promote the sense of security and equilibrium. This interaction takes place within a particular environment which itself has stable and variable factors which again promote a sense of security and equilibrium or promote aggression.

The model is suitable for analysing aggressive episodes, team-supervision, counselling of teams, clients, relatives and is convenient as a checklist for self-supervision

Method

After face validity was attested by research fellows, a table was derived and the applicability of the model in multiple settings was tested by asking experts of the field to complete the table.

Results

Finally we got completed tables from: Accident and emergency department, Community nursing, Drug and alcohol dependency treatment and detox, Forensic care, General hospitals, Gerontology and dementia care, Ambulance paramedics, Nursing students, Nursing homes, Pediatric care, Psychiatric inpatient care Children and adolescent psychiatric inpatient care and Homes for people with learning disability.

By this way applicability was accredited. Users of the tables reported that it was easy to complete the part which asks for elements which promote aggression. And they reported that it was more difficult to complete the sections of resources. But the latter was perceived as the most fruitful part of consideration. Interestingly, many adaptations towards strengthening the sense of security and equilibrium which were derived from the table were rather easy and cheap to implement.

Discussion

The completed sheets show the applicability of the NOW-Model in table form. However, users should test the transferability of the results to their own particular settings.

Learning objectives

Participants...

1. are sensitised to an integrating respectful interactionist and situational approach which considers not only flaws but abilities of clients, staff and environment for maintaining or promoting sense of security and equilibrium.
2. will understand that the discussion of aggressive episodes within a team should have more emphasis on elements which promote sense of security and equilibrium.

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Organizational Contributions to Healthcare Worker (HCW) Burnout and Workplace Violence (WPV) Overlap: Is this an opportunity to sustain prevention of both?

Sub-theme: Creating aggression and violence minimizing cultures

Paper

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Keywords: Workplace violence, healthcare environment, healthcare worker burnout, organizational culture

Background and Context

Efforts to sustain WPV prevention frequently get derailed despite how WPV affects quality and safety of patient care (Privitera MR and Arnetz J, 2011). Many “mainstream medicine” competing demands occur in running a healthcare system, and WPV prevention often falls from high priority status that it typically has after an extremely violent event occurs, despite the best intentions of caring administrators and clinicians. WPV has a spectrum of forms (Privitera MR et al 2015A). In more extreme forms it is generally low frequency but high impact.

HCW burnout for decades had been relegated to the individual worker to solve. Now extensive research demonstrates that HCW burnout is experienced daily by a high percentage of the HCW and affects the individual, other staff, the institution and the patients under their care (Lin Y-W, 2013).

There is a large overlap of organizational contributions to Burnout and WPV. Healthcare system awareness of the many devastating effects that HCW Burnout has is a newly emerging area, and increasing efforts are occurring to try to prevent Burnout (Rosenstein AH 2012, Privitera *et al.* 2015 B). Could efforts to reduce overlapping organizational contributions to both Burnout and WPV be a missing strategy that may be able to sustain prevention of both? See Table 1.

Methodology

Review of the literature shows directional relationships and a vicious cycle model can be built.

Findings

Organizational factors contribute to Burnout, Burnout can contribute to WPV, organizational factors contribute to WPV, and then WPV can contribute to Burnout. Overlapping contributory themes of both organizational contributions to HCW burnout and organizational contributions to workplace violence may help inform better interventions with potential to reduce and prevent both.

Implications for Practice

Focusing on the overlapping factors in organizational contributions to burnout and WPV, an informed strategy emerges. Suggested interventions for healthcare systems to interrupt this cycle and reduce the organizational contributions to Burnout and WPV are outlined:

- Management/ Triage: Ways to incorporate “Quadruple aim” in healthcare- good quality of care, control of costs but improved patient experience and improved HCW experience of providing care. (Compare: Triple Aim- Berwick et al 2008, with Quadruple Aim-Sikka R *et al.* 2015 and Bodenheimer T and Sinsky C 2014)
- Resource allocation: Decreasing extraneous cognitive load on HCW will improve decision-making quality and, allow for more intrinsic compassion to show through. Take material support requests seriously and done in thoughtful manner.
- Flow design: Efficient use of design and HCW support services reduces distractions from care of patient

- Cognitive overload/administrative toxicity: Be parsimonious with requirements, mandates and regulations; be aware of potential unintended consequences, as too many becomes impossible to do and paradoxically unsafe.
- Communication/ Information: Administration ↔ HCW ↔ Patient
- Lack of social support: Improve availability of HCW to be supportive to patients and HCWs supportive to each other.
- Lack of control of environment: Allow those closest to the problems to be involved in the solutions
- Emotion management: Wellness efforts to encourage self-assessments of stress and reactions to stress. Provide teaching/ coaching opportunities to manage the strong emotional situations of healthcare
- Emotional work and distress: HCW and administration to be aware of emotional work load in clinical situations, and especially after critical incidents. Anticipate needed time and resources for recovery. A staff support committee can work out resources and support protocols.
- Psychological contract violation: Disappointment that occurs with perception that organization broke its work-related promises (e.g. HCW takes a new job being led to believe that quality of patient care is institutional priority. Then if overly caustic business of medicine practices prevail, poor organizational health becomes clear, poor HCW performance ensues).
- Physical design issues: Work flow design affects efficiency, noise levels, causing adverse work and healing environment conditions. Patient and staff interactions under stress are more likely to become difficult interactions if physical designing is poor.
- Organizational Trauma: Can be sudden or cumulative. Traumatic event (s) that occurred at the organization, including mergers and acquisitions, downsizing or threats of downsizing. Strengthen the organizational identity and esteem. Acknowledge the trauma and how it can affect HCW sense of security, self-worth, wellbeing and engagement in order to move forward.

Table 1.

Organizational Contributions to Burnout	Factors Common to Both	Organizational Contributions to Workplace Violence
<p>Job Characteristics</p> <p>Job Demands:</p> <ul style="list-style-type: none"> • Quantitative: Workload, overtime, time pressure. • Qualitative: Role conflict, excessive extraneous cognitive load demand (detracting from germane and intrinsic cognitive load needed to do the work). • Role ambiguity. <p>Job resources:</p> <ul style="list-style-type: none"> • Lack of information, poor communication. • Lack of control on schedule and workflow issues (little participation in decision making). • Lack of autonomy, lack of social support. <p>Organizational and management environment:</p> <ul style="list-style-type: none"> • Organizational context shaped by larger social, political, cultural and economic forces. • Emotion-work variables: requirement to display or suppress emotions on the job, being “professional”, • “Self-effacement” despite stressors from systems, patient, personal or staff issues. • Requirement to be emotionally empathic as part of the work. • Violation of psychological contract (training ideas vs. business goals). • How one is treated by the employer and appreciation of what the employee puts into the job- crucial in maintaining staff wellbeing. <p>Organizational Characteristics:</p> <ul style="list-style-type: none"> • Complexities in hierarchies, operating rules, resources, space distribution, level of chaos, space design, fairness and equity, distributive justice of resources. 	<ul style="list-style-type: none"> • Management/Triage. • Resource allocation. • Flow design. • Cognitive overload/ • Administrative toxicity. • Communication/Information. • Lack of social support. • Lack of control of environment. • Emotion management. • Emotional work and distress. • Psychological contract violation. • Physical design issues. • Organizational Trauma. 	<ul style="list-style-type: none"> • Clash of people/ physical design. Crowding, forced together by difficult circumstances. • Complexity of system in getting help and effect on cognitive load when in pain and distress. • Lack of progression/ frustration: waiting without any sense of progression. • Zero Tolerance Policies (Overrides professional discretion and expertise. Reflex reaction to complex problem). • Perceived inefficiency: Dealing with Electronic Medical Record inefficiencies, documentation requirements, mandates, laws and regulations that are uncoordinated with each other. • Patients observe themselves and others seemingly waiting for hours while staff “busy themselves” with perceived non-essential tasks. • Forfeiting of control in chaotic setting -Lack of information from administration to staff and staff to patients. • Lack of support during duress. • Perceptions that hospital/staff in it for the money (mirror image violation of psychological contract perceived by staff). • Staff fatigue: Highly demanding work on staff, over time, physically and emotionally tired, staff make more errors and are more disinhibited, constant flow of patients. • Human resource shortage undermines violence prevention standards. • Inadequate assault/violence prevention training procedures and policies. • Tacit acceptance of violence as part of the job (instead of a risk of the job). • Inhospitable healing environments, inhospitable work environment. • Dehumanizing environments. • Intense emotions: pain, stress, witnessing others in their stressful experiences. • Unsafe environments: Equipment, intrusions, loud noise, lack of egress in space design, isolation from others.

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Learning objectives

Participants will...

1. have a basic understanding of a strategy to focus on overlapping organizational contributions to WPV and Burnout in HCWs.
2. have an understanding of how above interventions may augment and sustain current systemic efforts to prevent WPV while preventing HCW Burnout.

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Minimizing workplace bullying by promoting dignity and respect at work

Sub-theme: Creating aggression and violence minimizing cultures

Paper

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Keywords: workplace bullying, promoting respect, changing workplace cultures

Background and context

Workplace bullying is prevalent abuse consisting of repeated, offensive behaviours humiliating or intimidating others at work (Carbo & Hughes, 2010). The reported incidence varies with type of abuse and measurement methods but world-wide rates are increasing. WHO identified workplace violence an international problem (WHO, n.d.). We know that workplace bullying has effects on physical, emotional, social, and financial health. Our research has shown that workplace bullying influences how women and men take care of their health and their ability to work (MacIntosh, 2012; MacIntosh *et al.*, 2014). These studies have highlighted the importance of appropriate action and support to manage and prevent workplace bullying. I will discuss findings that show the importance of promoting respect and dignity at work in order to diminish violence in work cultures.

Method

We used grounded theory to study and develop an understanding of how men and women took care of their health and how they worked following workplace bullying. We recruited samples from the community and interviewed 36 adult men and 40 adult women, ranging in age from 22 to 81 years (average age 48 years). Most participants had some high school education and many had gone to university. Participants in these studies worked in healthcare, offices, trades, labour, and business in cities, towns, and villages and in both large and small workplaces.

Findings

About half of targets (people bullied at work) were bullied by people of the same sex and about two-thirds were bullied by bosses while one-third was bullied by co-workers or groups of them. Most targets of bullying reported emotional bullying. Over two-thirds of targets were fired, laid off, or forced to retire early because they were blamed for being bullied. Only about one-quarter of targets stayed in their workplaces. I will not discuss the separate processes used by men and women that emerged in these studies but I will elaborate on further analysis.

Implications

Further analysis of data from these separate studies showed what bullied women and men believed needs to be done to help them to restore their dignity and to promote respectful cultures at work. I will talk about what targets thought could be changed in workplace policies and procedures to diminish cultures that accept abusive behaviours. I will talk about strategies targets used at a personal level to maintain their dignity, including how they sought help and support and which resources were helpful.

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Learning objectives

Participants will...

1. understand how workplace bullying challenges people's abilities to care for themselves and continue working.
2. learn how workplaces can foster respectful interactions that prevent workplace bullying and protect the dignity of workers.

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Engaging and managing angry young men with mental health issues: a six-session intervention

Sub-theme: Creating aggression and violence minimizing cultures

Workshop

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Keywords: Homicide, Risk, Treatment, Neuropsychotherapy, Intervention

Background

Engaging antisocial clients presents considerable difficulty, particularly when the impact of acquired brain injury (ABI) and/or mental illness exacerbates premorbid personality traits. The function of anger is often misunderstood, where diagnosis of antisocial personality essentially reflects a description of behavior rather than etiological understanding. The workshop provides a biological and psychological foundation for understanding and validating the function of anger, which is usually a reflection of unmet emotional need.

Aims

Aims are to equip clinicians to engage and assist difficult clients in identifying behaviors that address unmet need.

Key Points

(i) Summarising biological building blocks of emotion processing; (ii) Learning the nature and function of anger and how to validate its healthy role; (iii) Review research evidence by the author examining olfactory deficits across the neurodevelopmental spectrum to demonstrate the link between emotional dysregulation and neurodevelopmental compromise; (iv) Detail aims, target group and 6 session intervention package for the engagement and management of angry clients at high risk for homicide, suicide and aggression.

Procedure

Power Point presentation includes interactive exercises.

Participants

This workshop is intended for mental health workers (allied health, psychiatrists, counsellors, drug and alcohol workers, psychologists) employed in private or public mental health whose clients present with unpredictable violence, general aggression, formal antisocial personality disorder or traits and/or risk for homicide.

Learning objectives

Participants will...

1. learn how to increase client engagement and advance emotional intelligence.
2. gain an acquaintance with the structured 6 session treatment package for possible utilisation in clinical practice.

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Workplace aggression among healthcare professionals in Nigeria: Psychosocial and cultural explanations

Sub-theme: Creating aggression and violence minimizing cultures

Paper

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Keywords: Workplace aggression, Healthcare Professionals, Psychosocial, culture, Nigeria

Abstract

There are mounting evidences of workplace aggression in healthcare sector and that the phenomenon rears its ugly head factually on daily basis among health practitioners in Nigeria, but in reality only a few cases got mentioned or investigated. The present article was motivated by the persistent incidences of work place aggression, which lends credence to the fact that much still need to be done in terms of unearthing the root cause and what sustains the practice. Thus, it becomes pertinent to look at both psychosocial and cultural perspectives that underpinning workplace aggression, particularly in Nigeria. The article provides psychosocial basis of aggressive behaviour among doctors and nurses and cultural practice that sustains this behaviour. The psychoanalytic theory and neo-psychoanalytic drive theory were combined with social-demographic attributes to explain the root causes of aggression embedded in doctors and nurses relationship. Also, 'culture of silence' which seems embedded in African practice is used to encapsulate why the behaviour is sustained in healthcare sector in Nigeria. The article proffered the way forward from the perspective of psychosocial adjustment and cultural re-orientation was also recommended to stem the problems.

Introduction

The tendency for aggression rearing its ugly head in every human habitation is very high, given the general knowledge of individual differences, temperament and complexities natures of Homo sapiens (human beings). The most important element in industrial organisation is people, which comprise individuals with different backgrounds. Thus, workplace is not immune to aggression, since it assembles different shades of personalities. Consequently, experience of bitterness, exchange of words, verbal abuse, physical assaults and other forms of human excesses may not be strange to such settings. Workplace aggression is another dimension of violence in hospitals and is assuming alarming rate which portends dangerous trends for the generality of people in Nigeria. Nowadays, expression of aggression seems no longer between psychiatric patients and professional caregivers (Ukpong, Owoye, Udofia, Abasiubong & Ukpong, 2011) or patient's relatives and the latter, but among healthcare team (Physicians, Nurses, Pharmacists, Laboratory Attendants, Radiographers e.t.c.). The rate at which disagreement ensue among these professionals appears to be second to none and it poses threat to the right of patients to quality healthcare. The reason for this disagreement may sometimes be readily pinned to role ambiguity, but there seems to be more to it underneath than what appears to the populace as factor responsible.

Workplace aggression is a serious concern for organizations, whether it is called harassment, deviance, or bullying, it can lead to a number of disturbing outcomes for organizations ranging in severity from low morale to injury and even death of personnel in most extreme cases (Hershcovis, Turner, Barling, Arnold, Dupre, Inness, Leblanc & Sivanathan, 2007). Although aggression in hospital may have received attention lately (Hills, Joyce and Humphreys, 2012, Ayinde, 2012), but the issue still remains persistent. Thus, it becomes pertinent to dig more into the root cause(s) of this phenomenon. Hence, the discussion in this paper x-rays the contentious relationships among doctors and nurses, the patterns and the cause(s) of this problem in hospitals and recommends the way forward.

Pattern of Aggression between Doctors and Nurses in Nigeria

In Nigeria, health care providers can be categorized based on source of funding and its management into government or public hospitals, private hospitals and faith-based hospitals. The National health system is made up of 3 levels of care namely; primary, secondary and tertiary. Primary health centres (provide primary level

of care) are funded by the local government authorities with technical assistance from the state government. The general hospitals (provide secondary level of care) are owned and funded by the state government while the teaching hospitals and other special hospitals (provide tertiary level of care) are owned and funded by the federal government (FMOH, 2004). For the purpose of this article, search light is in the direction of teaching hospitals, purposely because these hospitals provide an intensive and extended level of care to the citizen.

In Nigeria, the patterns of contentious relationships between doctors and nurses may be different from what obtains elsewhere. Afolabi (2014) posited that while the war between nurses practitioners and doctors is being done using legislative lobbying and empirical evidence, the professional civility and self-respect has been thrown to the winds as some Nigerian doctors handle this situation in an appalling manner, using a combination of verbal brawl, comical assertions and frustrated rants. A number of reported cases and findings from investigations clearly attest to this fact. For instance, Ogbimi and Adebamowo (2006) reported that nurses had better opinion of doctors' work than doctors had about nurses' work. i.e., there was perception of lack of appreciation of the knowledge of the other professional group by both nurses and doctors, but this was more prevalent among doctors than nurses. This implies disregard for other's profession and is characterised by unending criticism. In another dimension, older nurses may also expect traditional cultural respect due to an older person from often relatively younger doctors, this has also been identified as one of the sources of conflicts between doctors and nurses (Ogbimi & Adebamowo 2006).

Psychosocial Basis of Aggression: Psychoanalytic Perspective

Freud initially sought to derive all manifestations of human behaviour from one basic life instinct, designated as Eros. Conceived of as a force, this life instinct was referred to as libido which functioned to enhance, prolong, and reproduce life. Freud showed very little interest in aggression, as such, in his early writings. In 1920, however, he proposed a dual-instinct theory in which the life instinct was matched by a death instinct, termed Thanatos (Freud, 1920). This instinct was conceived of as a force urging the disintegration of the individual and human life at large. The relationship between the life and death instinct is polarized and any destructive or non-destructive activity can be construed as the specific interaction of the antagonistic forces. Freud also claimed that feelings of anger and hostility result in conflict and unconscious guilt in the same manner that sexual wishes do, and that these effects initiate defensive activity.

Furthermore, he observed that many impulses contain both sexual and aggressive components, and that many clinical manifestations, including sadism, masochism, and ambivalence, can be explained in terms of varying degrees of conflict between these drives or their fusion. In Freud's view, the death instinct forces the individual to direct aggressive acts against the social and physical environment in order to save themselves from self-destruction. Displacement and sublimation were introduced as central dynamic agents in the conversion of the potential attack on the self into an outward redirection. This inner dynamic process was instrumental to very different behavioural outcomes, such as coping, creativity, self-destruction, and aggression toward inanimate objects and living beings. According to the dual drive-theory, if the aggressive impulses are not combined with or adequately "bound" or fused with love, then increased aggression and destructiveness can be expected. In case of such failures, destructive energy will accumulate and, in its primitive form, result in destructive behaviour. Freud entertained the notion of catharsis or tension reduction in connection with destructive energy. Catharsis refers to a process in which the affective, non-destructive display or hostile and aggressive inclinations can discharge destructive energy and thereby reduce the strength of these inclinations.

Neo psychoanalysis theory, that is, drive theory propounded by Dollard, Doob, Miller, Mowrer, and Sears (1939) also provides valuable explanation for human aggression. According to Dollard, et al, (1939) drive theory was predicated on the frustration-aggression hypothesis. They were motivated by a wish to expanding on Freud's theory by translating the Freudian instinct propositions into more objective behavioural terms which could be put to empirical test. The original hypothesis first posited that any interference with an individual's goal directed activities cause frustration. In the frustration-aggression hypothesis, not only those factors that will determine how frustrated an individual will become was specified, but also how and when aggression will be expressed. Thus, the premise of the frustration-aggression hypothesis is that when people become frustrated (thwarting of goals) they respond aggressively. "The occurrence of aggressive behaviour always presupposes the existence of frustration and, contrariwise, that the existence of frustration always leads to some form of aggression" (Dollard *et al.*, 1939, p. 11). Thus, according to the theory, aggressive behaviour emanates from an aggressive drive, which means that it is not only initiated due to perceptions of frustrating external stimuli. Understandably, this represents a breach with Freud's instinctual understanding by the fact that aggression is understood as a reactive phenomenon. The blocking of an ongoing goal response leads to a build-up of aggressive energy within the organism. This energy is noxious and must be released

by the organism in the form of aggression. Any response that releases this aggressive energy is an instance of aggression.

Implication of Psychoanalytic theory

Aggression is defined as an intra-psychological phenomenon. The death instinct is its basic source of energy, but this energy can also result in creativity, coping, or self-injurious behaviour. However, the latter happens to be the most frequent expression from death instinct impetus. But since prevention of self-destruction is inevitable to guarantee existence, human beings result to displacement and sublimation defence mechanisms by redirecting attack to our fellows. One could note that the tendency to be aggressive stems from our unconscious mind and operates through our sub-conscious and finally capture our conscious mind by way of identifying objects or subjects of outward redirection of self-destruction attack. Perhaps, that is why Freud posits that the definition is process oriented and of an intuitive nature. According to this theory, aggression is natural and all human beings are potentially susceptible. The implications of the theory to this discourse are numerous; firstly, it portends that doctors and nurses like any ordinary individuals can also succumb to pressure of the need for displacement. This explains natural hostility toward one and another even though may sometimes be coloured by situational factors. Secondly, it is also an indication of inevitability of hostile behaviour among human beings in general and between doctors and nurses in particular.

Moreover, explaining humans' aggression from the perspectives of drive theory could be understood in terms of perception of blocked goal(s) or aspiration(s) by an individual that translate to frustration and subsequent reaction (aggression). This is often apply subconsciously to relief oneself of the whole burden. Thus, it could be hypothesised that doctors and nurses being humans are also prone to frustration, which might compel a release of response representing an instance of aggression. Perceived external factors that can jeer-up frustration in doctors and nurses are numerous and traceable to different areas such as work place, job conditions, career aspiration, home front, and other social and personal attributes. One can deduce that the more these groups of health professionals perceived blockage on effort to achieve optimum on any of their desires, the more response that culminate into instance of aggression feature in their day to day interactions with fellow human beings.

Social-Demographic Antecedent of Aggression in Hospitals

Hinged on Drive theory of Dollard, et al (1939), which focused on perception of external factors as determinants of frustration that leads to aggression build-up in individual, there are countless number of external factors that can trigger aggression in human beings. Some of them are categorised under social demographic factors.

- **Age Difference:** Age disparities among doctors and nurses is not unusual but when it is related to work relationship among these categories of health professionals, it becomes an issue. In Nigeria hospital, it is not uncommon to see older nurses in professional relationship with medical doctors who are relatively younger. However, the problem arises from the professional roles statutorily assigned to each member of medical team. Conventional practice in hospital settings stipulates that nurses should ensure compliance with various medical instructions given to the patients by doctors, but perceived age gap which is common among nurses often stem the feelings of resistance to doctors' instruction and sometimes exhibit despicable behaviour toward them. The matter becomes serious because of value attached to age in Nigeria. Corroborating this position, is the study of Ogbimi and Adebamowo (2006) who identified the older nurses' expectation of traditional cultural respect due to an older person from often relatively younger doctors as one of the sources of conflicts between doctors and nurses in Nigeria.
- **Differences in Training Schedule:** Different profession requires different training schedules. It is a public knowledge that the number of years and schedules of training between medical doctor and nurse are not similar. While the medical doctor undergo a long years of training and some other professional trainings after the first qualification to become a consultant etc. the nurse on the other hand undergo lesser years of training and a few professional trainings. The disparity in the number of years and training schedules between doctors and nurses has potential to spring up rivalry relationship among them and this may fan the ember of hostility.
- **Length of Service:** In many of the hospitals in Nigeria, it is not unlikely to see a staff nurse who has spent a good number of years in service ahead of a medical doctor who will automatically become leader of medical team as soon as he completes his residency. This development is capable of causing frustration among staff nurses. In fact, several studies (Ugwa, Muhammad & Ugwa, 2014) have attested to this fact. A

staff nurse who interprets the situation as 'ajosepo laarin Oga ati Omo-ise' (boss and servant's relationship) has tendency to experience the kind of frustration, which may be attributed to external environment and its attendant reactions as described by Dollars *et al.* (1939). Other socio-demographic variables that may serve as antecedent of aggression in hospital include; Medical Professional Roles and Gender Difference.

A Culture of Silence and Aggression between Doctors and Nurses

Today, there seems to be popular beliefs among people in Nigeria that one has to develop thick skin or absorb untoward behaviours or comments from their fellows. In psychology parlance, this development may at first be attributed to a feeling of helplessness, but when one looks at it from habitual and attitudinal approaches, it conveys individual's belief system. This belief could best be described as 'a culture of silence'. Silence here, goes beyond the state of a void or absence of voice (Armstrong, 2007) or the absence of communication (Bloomer, Griffiths, and Merrison 2005) rather, it connotes meaning. In Nigeria context, it could be a form of response originating from indifference posture and sometimes connotes 'do me I do you or do somebody else' mentality. This appears to have become a sort of cultural norm in Nigeria. Madubi (2010) posited that silence in Nigeria is an iconic of specific behavioural responses conveying some cultural norms aimed at ensuring the sanctity of the community's well-being.

Reading the phenomenon of culture of silence into aggression between doctors and nurses in Nigeria could be understood from its potential role in prolonging the problem among these categories of health professionals. This paper argues that the prevalence of a culture of silence among the stakeholders could be responsible for a prolong skirmish between doctors and nurses in hospital. The stakeholders are policy makers (Health Ministry, Governing Council) Administrators (Hospital managements and other constituted authorities), Regulators (professional bodies) and health workers themselves (Doctors and Nurses). The prevailing circumstances regarding the relationship between doctors and nurses nowadays is indifference posture of the stakeholders about the matter.

Moreover, a culture of silence also prevails among different professional bodies in Nigeria. One of the major duties of each professional body is to ensure that members adhere strictly to the basic ethical issues and professional conducts that are peculiar to each body. The work ethic in hospitals, especially working relationship between a staff nurse and a doctor should be parts of professional conducts, which different professional bodies should inculcate during induction into each of the bodies. But the problems most often arise from the inability of the professional body to monitor the conducts of the members while in service and in practice. This may not be unconnected with the fact that many of professional bodies do lack structure to monitor but sometimes, prefer to establish structure to adjudicate on complaints and petitions written against members, and in most cases disciplinary actions often delay. All these portend a culture of silence among professional bodies and the working relationship between doctors and nurses suffer for it. The dimension of a culture of silence among doctors and nurses themselves has become an attitudinal matter. Ordinarily, individual's response to a form of despicable behaviour or an act from other fellow should be personal, but the reaction from both ends, that is, doctors and nurses' perspectives seem to be tending toward a system of belief.

The Way Forward

Having established the psychosocial basis of humans' aggression and its inevitability among health professionals, particularly between doctors and nurses on one hand and the cultural context that can sustain the aggression between these categories of health workers on the other hand, there is need to proffer solutions to this seemingly intractable problem. Thus, this paper attempts to offer the way out of this quagmire from the two perspectives in which aggression sources are earlier traced; psychosocial adjustment and cultural re-orientation.

Psychosocial Adjustment

Psychosocial adjustment dovetails into personal and social adjustment. Adjustment in itself would describe a satisfactory relation of an organism to its environment. Environment consists of all surrounding influences or forces, which may influence an organism in its efforts toward maintenance. It could be in three folds; the physical, which consists of all outer physical and natural surroundings; the social, which is the society of other like individuals, institutions, customs and laws by which individuals regulate their relationship to one another; and the self-environment to which a person must react, manage and get along with. But for the purpose of this discourse, social and self environments would be instrumental to controlling of aggression among doctors and nurses. This paper is recommending psychosocial adjustment in terms of effective adaptation, which revolves around the reduction of inner needs, strains and conflicts. In this meaning of adjustment, there is no single

ideal of normality or personality. However, Adler used the term 'style' to indicate the particular adjustment pattern. 'the self-consistent personality structure develops into a person's style of life and this style is moulded by people's creative power' (Fagurson, 2003: 3). Using this template, there are several styles and some of these styles culminate into psychosocial adjustment. A few of them are considered useful to address the issue of aggression between doctors and nurses in hospitals. They are as follows;

Integration: the first criterion of good adjustment is freedom from inner conflict. It means the resolutions of conflicting personality trends. A well-adjusted person presents a solid, unbroken front to the world and is free from competing trend within. He or she has resolved his or her early ambivalence and is able to achieve reconciliation of freedom and discipline. This paper argues that if doctors and nurses could achieve this level of integration within, it will go a long way in reducing in-built tension that gives rise to aggressive behaviour among these categories of workers.

Ego Development- Effective Intelligence: the highest evidence of successful adjustment is getting along in the world around one, particularly with one's fellow men. Effective adjustment means the sublimation and socialization of basic unconscious impulses and drives. This paper is of the opinion that if nurses and doctors can collectively and individually imbibe this principle of psychosocial adjustment, their outward expression of anger could be controlled.

Acceptance of Reality: a good adjustment is ability to accept particularly the reality within. The person who is well adjusted recognises the reality and inevitability of the conditions to which he must adjust. Freud (1920) described adjustment in terms of the pleasure principle and the reality principle. The pleasure principle dominates infancy, when there is failure to recognise the condition imposed by outer circumstances. But only when a person modifies his/her longings, on one hand, and his/her mode of satisfying them, on the other hand, to the condition imposed by outer reality, is he/she making a good adjustment. Thus, a well-adjusted doctor or a staff nurse learns frustration, tolerance, which is ability to postpone gratification until condition is ripe to grant them. Moreover, there are other useful psychosocial adjustment elements which can help stem the tide of aggression in hospital, which include; Responsibility for Self, which emphasis that a particular importance for good adjustment is the ability to take responsibility for one's own feelings; Emotional Expression- the well-adjusted person is the one who, in addition to these capacities for self-control, has certain freedom of emotional expression and Social Relationships, which stipulates that a well-adjusted individual is one who lives with others and enjoys social contacts and interests.

Cultural Re-Orientation

Tracing the factor that sustain aggression to culture of silence phenomenon makes cultural re-orientation inevitable among different categories of health professionals, particularly between doctors and nurses. According to Tsai and Chentsavo-Dutton (2001) cultural orientation is a degree by which individuals are influenced by and actively engage in the traditions, norms and practices of a specific culture. Omijie (2015) describes an orientation as an integrated set of attitudes and beliefs, while reorientation is the act of changing the direction in which something is oriented. It is a fresh orientation; a changed set of attitudes and beliefs ("reorientation"). This paper presupposes that doctors and nurses and other stakeholders have been influenced and engaged actively in a culture of silence practice, and as such, there is need for cultural reorientation. In psychology, cultural re-orientation could be predicated on the concepts of learning and unlearning. Organisms are capable of learning and unlearning a particular set of behaviours. This goes for doctor, nurses and others stakeholders mention in the course of this discussion. This paper argues that if a culture of silence is learned and practice among these categories of people, it is possible to unlearn it. Thus, it becomes imperative to re-orientate ourselves on the need to make affirmative statement or action on every situation that is interpreted or perceived as hostile to our general well-being. It is recommended here that all the stakeholders; Health Ministry and Govern Council should address the matter with prompt attention required; professional bodies should take proactive steps aiming at monitoring members' work related activities; and most importantly, doctors and nurses should re-orientate themselves towards being objective in their dealings, contributing their quota to team with utmost professionalism and to cultivate the habit of 'give and take' principle in dealing with issues that can lead to hostility behaviour.

Conclusion

The persistent cases of aggression in our hospitals, particularly between doctors and nurses, nowadays may have received some considerable attention from the scholars, but more efforts are still required to nip the problem in the bud. As a result, this paper explored the basic psychological theories and demographic factors that serve as antecedents of aggression as a component of human behaviour. Generally, human aggression was

explained from the perspectives of psychoanalytic and derive theories as well as social demographic factors that are peculiar to individuals or groups. The likelihood of these socio-demographic factors influencing aggression between doctors and nurses is discussed, even though the actual relationships between aggression and perception of some of the socio-demographic factors could still be subjected to empirical testing. This notwithstanding, it is arguably fact that these factors have high propensity to explain aggressive behaviour between doctors and nurses in hospitals. Meanwhile, this paper made efforts to proffer solution using psychosocial adjustment and cultural re-orientation, where doctors and nurses as well as other stakeholders are encouraged to cultivate styles of adjustment and re-orientate themselves on the issue of culture of silence.

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Learning objectives

Participants will...

1. learn about prevalence and patterns of aggression in Nigeria health institutions.
2. learn about the psychosocial basis of aggressive behaviour among doctors and nurses.
3. learn about cultural practice that sustains aggressive behaviour, and how to minimize aggression in hospitals through cultural re-orientation.

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Workplace Violence: Pearls from the Pearl of the Antilles

Sub-theme: Creating aggression and violence minimizing cultures

Paper

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Keywords: Workplace violence, international perspective, descriptive study

Introduction

Workplace violence (WPV) against healthcare providers is a significant problem garnering international attention. The World Health Organization defines WPV as incidents where staff are abused, threatened, or assaulted in circumstances related to their work. While WPV is a known problem in the U.S., there are no data available to compare the rate of violence in the United States (U.S.) to that of a socialist neighbor, specifically the country of Cuba.

The purpose of this descriptive study was to identify if WPV was an issue in Cuba and what strategies were in place to mitigate the issue and protect healthcare providers. Data were collected using field observations and interviews with Cuban nationals.

Cuban nationals reported that WPV did not exist in the same manner or degree as it does in the U.S. Respondents further reported that there is a strong respect for the nursing profession in Cuba. Nurses are highly valued for their contribution to the health system and to Cuban society. In fact, the role of the nurse was identified as being central to the overall function of the Cuban health system. Workplace violence is not viewed as burdensome in Cuba as it is in the U.S. The Cuban nurses relayed that patients often get angry or upset with their course of treatment or prognosis, but they expressed that they felt very comfortable with their ability to diffuse the situation, and call on the resources available to help the patient and/or family deal with the crisis. They believed that aggression during stressful situations was an expected part of the disease/symptom management process.

In the U.S., the influence of drugs and alcohol, and behavioral health issues are key indicators that fuel WPV. These factors did not seem to occur in Cuba, and therefore may influence the reported low incidence of WPV. Citizens and patients were commonly seen waiting for care; however, no violent outbursts were observed. In addition, narcotic medications are rarely prescribed, but when they are, the patient must report to the physician's office or they are delivered to their residence on a daily or weekly basis. Neighborhoods have small clinics where physicians and nurses work alongside each other and care for between 75 and 120 families. The physician usually lives in the same neighborhood as the clinic.

A consideration of four core values in the Hispanic culture can help explain the low incidence of WPV in Cuba: family, respect, personal relationships, and trust. These core values afford a high degree of respect to physicians and nurses in Cuba and indeed affect the overall view of the healthcare system by patients. Respect is enhanced by the structure of the Cuban health care system, which emphasizes primary care practices and prevention. After graduation, young professionals perform community work for one or two years with low wages, which may help foster empathy and understanding towards patients. Cuban healthcare providers can provide valuable information to the U.S. health policy experts and administrators regarding measures to reduce the incidence of WPV.

Conclusion

Dramatic redesign of the US healthcare system and innovative approaches to change culture is needed.

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Learning objectives

Participants will...

1. be able to compare the experience of workplace violence that occurs against healthcare providers in the United States and Cuba.
2. be able to explain potential causes for the low incidence of workplace violence in Cuban healthcare settings.

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The Northampton Violence and Aggression Prevention Scale (NoVAPS): Development of a new tool to measure the violence prevention climate

Sub-theme: Creating aggression and violence minimizing cultures

Paper

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Keywords: Prevention, Scale development, Violence prevention climate, Inpatient, Secure settings

Background

The activities undertaken by patients, staff and organisations at a ward level, to prevent violence can be described as the violence prevention climate. There are currently no valid and reliable tools that measure this aspect of ward climate.

Aims

To describe the development of the NoVAPS, a scale to measure the violence prevention climate in secure/forensic mental health inpatient settings.

Method

Scale items were developed from a literature review, patient focus groups and staff interviews. Items were subject to expert review and pilot testing with patients and staff. Subsequently, all patients and staff within mental health care pathways at St Andrew's Healthcare who fulfilled the inclusion criteria were invited to participate in a study to determine the factor structure of the tool, to assess its acceptability and cogency, and internal reliability. A subsample were asked to complete the scale on a second occasion to determine its test-retest reliability. The factor structure of the NoVAPS was tested using principal components analysis (PCA) and Rasch analysis using PCA of the residuals (PCAR). Rasch analysis, using mean square (MNSQ) measurements was conducted to measure item fit against the theoretical model and item redundancy. Differential item functioning (DIF) analyses were run to determine whether item invariance held between item parameters estimated for different groups (staff/patients; males/females) within the sample.

Results

Development strategy yielded a 40-item scale. In the main study the response rates were 93% (n=326) and 66% (n=95) for staff and patients respectively. PCA of the items yielded a 15-item, two-factor structure: staff actions' and 'patient actions'. PCAR corroborated that this was a multifactorial scale, and that each factor was unidimensional. All items demonstrated good fit statistics. Two items in the staff actions factor showed high levels of DIF between staff and patients and were removed from subsequent analyses. Two further staff actions items were removed as they returned high inter-item correlations.

Implications for practice

The NoVAPS is quick and easy to administer for patients and staff. The violence prevention climate comprises two factors relating to staff actions and patients actions. This can be measured using the NoVAPS, which demonstrates good internal validity using a variety of statistical methods. The NoVAPS has the potential to measure trends over time, as well as evaluate violence prevention initiatives.

Learning objectives

Participants will...

1. be able to describe and analyse the factors that comprise the violence prevention climate.
2. be able to understand the process of scale development.

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Examining the use of the DASA in mental health settings

Sub-theme: Creating aggression and violence minimizing cultures

Paper

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Keywords: Risk assessment, inpatient aggression

Introduction

Inpatient aggression is a common and ongoing problem, a significant workforce challenge (Bowers *et al.*, 2009; Cutcliffe & Riahi, 2013; Daffern, Mayer & Martin, 2003; Nijman, Bowers, Oud, & Jansen, 2005) and can cause physical and psychological harm to both patients and staff (Daffern, Howells, & Ogloff, 2007; Rippon, 2000; Ward, 2013). Risk assessment instruments such as the Dynamic Appraisal of Situational Aggression (DASA) can assist in identifying patients at elevated risk of aggression. These assessments can be used to identify patients in need of additional intervention, treatment and management. Although numerous studies have examined the predictive validity of DASA, few studies have explored issues with its implementation (Lantta, Daffern, Kontio, & Välimäki, 2015; Lantta, Kontio, Daffern, Adams, & Välimäki, in press) or reviewed its clinical utility in day-to-day practice, and there remains a paucity of research examining the impact of assessments on staff behaviour (whether risk assessments encourage staff to alter their behaviour and activate violence prevention strategies). This presentation will discuss a study designed to review the use of DASA in everyday practice to better understand the impact of DASA use in mental health hospitals.

Methods

A data collection survey was designed to elicit user's experiences of the DASA and to describe the advantages and limitations in using this type of risk assessment instrument. The data collection survey was sent to all individuals who have made contact with the DASA developers. Content analysis was used to analyse the data relating to the user's experiences of the DASA, and to describe the advantages and limitations in using this type of aggression risk assessment instrument.

Findings

Ten services responded to the survey. Out of these 10 services 7 had evaluated staff perspectives of use of the DASA, and reported that staff found DASA to be useful in their everyday practice, and helpful in recognising subtle changes in risk profile with patients. DASA was mostly completed by nurses, and training was provided to staff in a variety of methods (such as education sessions and e-learning). Services had devised different methods of communicating the assessment score to others, and the DASA assessment provided information and prompts for team members to carry out their work with patients and to develop specific plans to apply preventive strategies. However, in some instances it was suggested that by the time the DASA was rated nurses had already reacted and applied preventive strategies, and continued to rely on their own clinical judgement.

Conclusion

DASA assessments can assist in increasing awareness about the risk of imminent aggression and aid in the implementation of strategies to prevent aggressive behaviours from occurring.

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Learning objectives

Participants will...

1. identify some of the advantages of using a validated risk assessment tool.
2. learn that DASA as a risk assessment tool that can be used by nurses to assess risk and prompt interventions to reduce the risk of aggression.

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Enactors of horizontal violence in nursing: Implications for intervention

Sub-theme: Creating aggression and violence minimizing cultures

Paper

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Keywords: Horizontal violence, aggression, nursing, bullying

Background

Horizontal violence is an umbrella term used to describe a range of aggressive behaviors between nurse colleagues, from eye rolling to physical assault (Sheridan-Leos, 2008). Policies to address aggressive behavior in the workplace often include the word violence, when many nurses equate violence with physical assault, and the term bully, when the term implies malicious intent and refers to behaviors repeated over time. There is no agreed upon term for individuals who enact aggressive behaviors that are not physical, malicious, or repeated, contributing to a lack of recognition of lower-level, non-physical aggressions as problematic and perpetuation of the phenomenon (Crawshaw, 2009).

Although the cumulative effects of different aggressive behaviors are similar, the purpose and intentionality are not. We propose that to effectively combat horizontal violence, the enactors of related behaviors must be disaggregated into types, and these types should be named and approached differently. We also suggest a sequence of interventions that should be tailored to the specific circumstances of each aggression as identified through root cause analysis, with consideration for the context in which the behaviors occurred.

Methodology

The disaggregation of enactors of horizontal violence described in this paper is based on the identification of three types of enactors from a study of nurses' perceptions of the phenomenon across two hospital units in the Northeastern United States (Taylor, 2013). The study incorporated 370 hours of observation over a period of five months, document review of workplace violence policies, and over thirty interviews with administrators and nursing staff to explore the horizontal violence in context. The enactor types, the Pathological Bully, the Self-Justified Bully, and the Unprofessional Co-Worker, were identified during thematic analysis of the study data. A literature review focused on current interventions to address horizontal violence and related behaviors in nursing was also completed. Based on the study and literature review, we suggest a four step intervention.

Enactor Types

The Pathological Bully enacts bullying as it is most commonly defined, as repeated, intentional aggressive acts, involving power and control over a target or victim. This type of bullying is most often understood to be the result of personality defects such as a lack of empathy and moral compass (Gini, 2006; Piotrowski, 2015; Salin, 2003). Although there have been efforts to understand the role of social systems in this type of behavior (Salin, 2003), the primary focus is on the bully as a flawed individual. This enactor is the focus of many workplace violence policies.

The Self-Justified Bully is a term we propose to describe two types of enactors. The first is an individual, often a preceptor or supervisor, a teacher or co-worker, who enacts abusive supervision (Chu, 2014; Estes, 2013) or a "tough love" teaching style (Leong & Crossman, 2016). On the surface, this type of bully lacks the malicious intent of Pathological Bully, as the enactor justifies their behavior to themselves and others in desired, and often achieved, outcomes; properly trained nurses and properly cared for patients. This type of enactor may be difficult to detect as their actions can be mistaken for motivation, passion for the job or a demand for excellence. The second type of Self-Justified Bully is the nurse co-worker who hoards available resources (including assistance) to provide care to their assigned patients. This enactor often frames their behavior as necessary to do their job and as a form of patient advocacy, without considering their hoarding of resources may result in a co-worker not having resources to care for their patients to the same degree.

The Unprofessional Co-worker primarily enacts what are seen as low-level incivilities: eye rolling, use of condescending tone, and gossiping (Clark, Olender, Cardoni, & Kenski, 2011). Unlike bullying, which is repeated over a period of time, unprofessional behavior may occur in single or sporadic episodes. The Unprofessional Co-Worker may be unaware of their behavior. These enactors are framed as lacking the conscious malicious intent of bullying, as committed by a Pathological Bully, and the need to justify their behavior, as a Self-Justified Bully might. Co-workers socialized to accept these behaviors as part of the job may no longer recognize them as problematic, but to an outside observer (patients or visitors) or newcomer (a new hire or new grad) these behaviors are often identified as aggressive and unprofessional (Taylor, 2013). We propose this enactor is any one of us on a bad day, explaining the prevalence of these behaviors.

Intervention

There is limited research focused on the implementation of interventions to address horizontal violence. Results of a 2015 study of prevention strategies (Johnson) found interventions focus primarily on the individual, despite evidence implicating environmental factors as contributing to workplace aggression (Hutchinson, Wilkes, Jackson & Vickers, 2010; Purpora, Blegen & Stotts, 2012; Rodwell & Demir, 2012). Codes of conduct and workplace violence policies, and their enforcement, are generally based in a legalistic conception of bullying (Johnson, 2015) and focus on identifying the Pathological Bully. We suggest that organizations shift their resources and prioritize addressing lower level aggressions.

Our disaggregation of enactors of horizontal violence suggests a four-part intervention strategy. The first step is a commitment to change. Step 1: We propose the Unprofessional Co-Worker is responsible for the largest percentage of aggressive acts in the nursing workplace, and the affects of these acts are cumulative and damaging. To reduce the frequency of these acts requires cultural change. Culture is defined through the actions of the leaders, who must explicitly define acceptable and unacceptable behavior. They must role model expected behavior, provide clear guidelines for reporting, and create environments where reporting is safe. This requires organizational commitment of resources to monitor and address aggression, as mandated by the Joint Commission (2008). All employees must receive the same training to assure they have a shared understanding of the language and intent of policies, as well as reporting processes, as to act from a shared understanding of behavioral expectations and procedures. Leaders and administrators will require additional support and training to recognize and manage behavior, and to create behavioral remediation plans. There must be follow up to reporting, starting with a root cause analysis of context of the aggression, identifying and addressing contributing factors, whether they are personal, inter-personal, environmental, or systemic. This commitment is the foundation for any initiative to address higher level aggressions because the presence and prevalence of lower level aggressions serve as a breeding ground for more extreme forms of bullying and as a smoke screen providing cover for both Self-Justified and Pathological bullying.

The second step, which could be concurrent with the first, involves training in reflective practice, using an approach such as described in Taylor (2015). Step 2: A number of interventions involve training potential victims to stand up to aggressors and actively intervene on their own or others' behalf. This form of intervention is problematic because of the power dynamics of bullying, conflict avoidance, and fear of retribution. However, interventions such as cognitive rehearsal (Griffin, 2004; Griffin & Clark, 2014), that involve reflective practice and inquiry, could be effective tools to address the Unprofessional Co-Worker and Self-Justified Bully. This training provides an opportunity for awareness raising and inquiry that we see as necessary as a foundation for improved communication. Done well, this intervention provides individuals with an opportunity to make generous inferences about their colleagues and recognize their own contribution to conflict through skilled inquiry. These are the moves that sit at the heart of the reflective practice tradition (Argyris, Putnam, & Smith, 1985; Argyris & Schön, 1974; Kegan & Lahey, 2009; Schön & Rein, 1994; Schön, 1983; Taylor, 2015; Torbert & Associates, 2004). It is both as simple and as difficult as being able to separate intent from impact (Stone, Patton, & Heen, 2000), the ability to recognize that the impact someone else's action have on you may well be different than what they intended and that the impact you have on others may be different than what you intended. This is the foundation for productive conversations about problematic interactions. Ideally, such training can serve to create a sense of community and improve communication within nursing units.

The third step focuses on identifying and addressing environmental factors contributing to the persistence of aggression. Step 3: Although individual-focused interventions may be effective against Self-Justified bullying and aggression by the Unprofessional Co-Worker, the contribution of systemic pressures and environmental factors must also be addressed. We suggest root cause analysis be applied to all episodes of aggression and that staff at all levels be provided with tools and training to develop skills to participate in quality improvement initiatives. These skills would build on skills developed in Step 2. As nurses often ascribe behavior to an

individual's personality (Farrell, 1997) or "a bad day (Taylor, 2013)," a move to replace assumptions with inquiry could identify systems issues as contributing to aggression. These issues could then be addressed. This inquiry/root cause analysis could be framed as ongoing quality improvement, "We're good, but we could be better."

The fourth step, effectively identifying Pathological bullies, can only be taken when the first three have been successfully implemented. Step 4: Once behavioral expectations are enforced, staff have skills to engage in problematic interactions, and there is safe reporting, identification of Pathological Bully will be possible as their behavior will lay outside of established norms. Once identified, appropriate administrative action, such as terminating employment if behaviors do not change, can be taken.

Implications and Recommendations

This disaggregation of enactors of horizontal violence into three types and suggested sequence of interventions introduces an alternative approach to horizontal violence. Research indicates that nurses often do not recognize horizontal violence when they see it and do not use the terms from the literature to describe it or those who enact it. Identifying enactors of horizontal violence by enactor type may assist nurses and managers to identify behaviors requiring intervention. They may then be able to utilize the suggested sequence of interventions to address aggression within their work environments.

Limitations

This disaggregation of enactors and proposed sequence of interventions is based on one study of nurses working on two hospital units in the Northeast United States and may not be generalizable to other populations. However, researchers and practitioners can use these findings as a starting point to determine why efforts in other setting are not succeeding and how they might change practice. Further research focused on enactor types and testing of the proposed sequence of interventions, as well as the development of future interventions, is required.

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Learning objectives

Participants will...

1. be able to identify patterns of behavior associated with horizontal violence, as well as attributes and actions of potential enactors.
2. have an understanding of an alternative strategy to identify and address horizontal violence in their workplace.

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Interdisciplinary simulation program with the psychiatric emergency staff to improve communication and acknowledge implicit bias

Sub-theme: Creating aggression and violence minimizing cultures

Paper

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Keywords: Safety, simulation education, communication, aggression, implicit bias, staff education, aggressive patient management

Abstract

In a large urban academic hospital the adult psychiatric emergency department service team consists of two psychiatric nurses, a psychiatric clinical technician, a rotating psychiatric resident and two to three security officers. Together all staff attend annual training focused on de-escalation and hands on safety techniques.

On average 330 psychiatric patients are seen by this service for crisis intervention each month; the majority ethnic/racial minorities. Approximately 25% of the people are involuntarily brought in by the police or other referring services. 40% of all patients are admitted to inpatient psychiatric services with an average length of stay in the ED of 28 hours or more.

Health care providers and corporate security can be at odds regarding the best interventions during an aggressive act as a result of professional perspective. Many of the security officers and those in higher rank served in the correctional system. The identified differences among the interdisciplinary staff related to the safe management of aggressive psychiatric patients resulted in increased hands on events, a perceived lack of support and ongoing communication issues.

A need for examination of the communication patterns between team members was identified by nursing leadership. A taskforce was created of nursing, security, and the office of Diversity and Inclusion. The team developed a pilot simulation program to identify interdisciplinary issues in team performance. Issues surrounding implicit bias were identified and the taskforce decided to investigate bias as a systemic issue with understanding of how individuals' perceptions play out in escalated patient situations. The following took place: specialty targeted focus groups, independent surveying and case simulations. Convenience sampling focus groups were conducted by a third party facilitator. An electronic survey measuring perceptions of safety was distributed to all staff. Simulation training was developed based on the focus groups. Actors were hired for patient roles. Three months after simulations, focus groups and the survey will be repeated.

Findings include observations from the simulation exercises, themes and recommendations emerging from the focus groups, and data examining escalation events pre and post intervention.

This program identifies the need for integrated multi-team education beyond traditional crisis prevention management programs with a focus on recognizing implicit bias and identifying tools to address it. The use of simulation activities are proven to be an effective multidisciplinary learning tool enhancing interdisciplinary communications and team performance. Implicit bias must be addressed as it has not only pervasive, but malleable for intervention.

Implications

- Standard crisis prevention programs do not adequately address communication and implicit bias that results in patient escalation
- Crisis prevention programs must include multidisciplinary communication and the recognition of implicit bias
- Creation of tools and policies to reinforce communication expectations
- Improved team communication decreases aggressive and hands on events.

Learning objectives

Participants will...

1. identify the role implicit bias plays in communication during aggressive or pre aggressive events.
2. be able to state the needed aspects of a multidisciplinary simulation program focused on communication and identification of implicit bias.

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Preventing and Managing Patient and Visitor Aggression in General Hospitals: Nurse Managers' Behaviours and Influencing Factors. A qualitative study

Sub-theme: Creating aggression and violence minimizing cultures

Paper

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Keywords: Patient and visitor aggression; nurse managers; aggression prevention and management; general hospitals; acute hospital; safer wards

Background and context

Nurses are frequently exposed to patient or visitor aggression, which not only poses a threat to nurses' mental and physical wellbeing, but also incurs substantial organisational cost due to missed time at work, burnout and increased staff turnover. Nurse managers have a central role in supporting nursing staff in the prevention and management of PVA. However, to date we lack comprehensive knowledge on the nurse manager's role in reducing PVA in the general hospital setting.

Aims

The aims of this study were twofold: (1) To investigate nurse managers' behaviours in the management and prevention of patient and visitor aggression in general hospitals. (2) To determine the factors that influence managers' behaviours.

Methodology

We conducted five focus groups with ward managers and deputy ward managers, and 15 individual interviews with divisional managers and directors of nursing in Switzerland between October 2015 and January 2016. All interviews were semi-structured. The interviews were transcribed and analysed in a qualitative content analysis. The Reasoned Action Approach provided the theoretical underpinning of this study and guided the analysis.

Findings

The preliminary results confirm nurse managers' key role in establishing and maintaining safer workplace cultures for nursing staff. Independent of their clinical area, nurse managers voiced great concern for the topic. Creating safer work environments requires nurse managers' continued engagement. Within their departments or areas of managerial responsibility, nurse managers' described three essential behaviours to manage and prevent aggression. These were (1) securing resources to equip personnel with necessary skills and knowledge, (2) continued assessment of the work environment and incidents to identify scope for improvement, and (3) maintaining close communication with staff. By working with other departments within the organisation, nurse managers (1) promoted patient and visitor aggression as a topic of high importance and (2) aimed to improve services by networking with other stakeholders. These included, amongst others, members of the board of directors, hospital legal service departments or police forces.

Nurse managers' behaviours were motivated by their passion to create work environments that ensured safety and wellbeing for staff and patients. Barriers to achieving this were lack of financial resources, organisational structures and processes, as well as conflict of interest between nurse managers' concerns and the interdisciplinary team or the hospital directorate's priorities.

Implications

This study provides novel insight into nurse managers' behaviours in the management and prevention of patient and visitor aggression in general hospitals, an area that to date remains underresearched. The study was conducted in Switzerland, which does not have any national policy against workplace violence in the health sector. Since the Swiss health care system differs from those of other countries, our results may have limited international applicability. We will ascertain the international applicability of the results in a further research project.

Learning objectives

Participants will...

1. appreciate that nurse managers play a key role in creating safer working environments for nurses in general hospitals.
2. appreciate that creating safer environments requires nurse managers' continued engagement.
3. appreciate that within their departments, nurse managers provide support by communicating, securing resources such as staff training.
4. learn that continued assessment of work environment and learning from incidents is essential to improve ward safety.
5. realize that within the organisation, patient and visitor aggression requires continuous promotion as a topic of concern against competing interests.

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Creating and Sustaining Cultures of Care: Minimizing Aggression by Maximizing Safety Related Behaviours

Sub-theme: Creating aggression and violence minimizing cultures

Workshop

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Keywords: Culture, Care, Caregiver, Safety, Behaviour Change

Abstract

Health care delivery systems are increasingly staffed by people with high levels of stress, and the acuity of individuals served is also increasing, especially in mental and behavioral health settings. Efforts strategically respond to these stresses have failed, resulting in increases in injury to staff in human service settings, as well as to individuals served. Using a model based on organizational change followed by strategic initiatives provides the optimal probability of success.

Overview

Peter Drucker, one of the foremost experts on organizational culture change, said that “culture eats strategy for breakfast.” (Drucker, n.d.) This phenomenon can be seen in the data regarding strategic implementation of efforts to reduce workplace violence in human service settings. In the last 10 years in the United States, workplace violence has decreased in all work sectors except health care, where it increased by 10%. The Health and Safety Executive data in the United Kingdom, measuring from 2014/2015, identified 4,810 occupational injuries in all workplace sectors. 52.3% were in the health care professions. (HSE, 2015) This increase comes in spite of significant national and international efforts to address the issues surrounding workplace violence in healthcare. Despite hundreds of articles, dozens of conferences, and millions of dollars or Euros being spent on strategic initiatives, the data shows the ineffectiveness of these strategic initiatives.

The strategic initiatives are in place for a variety of different reasons, and underlying many of them are attempts to manage the changing methodologies to pay for human services, including health care. Heraclitus said that the only constant in life is change, and he made that observation in approximately 385 bce. Whether it is the National Disability Insurance Scheme in Australia, the Affordable Health Care Act in America, or National Health Service (NHS) restructuring in the UK, change in the way services are funded are adding stress to an already overstressed and overburdened system. Despite all these efforts to minimize risk and increase safety, injuries continue to occur, and not just physical injuries. Many children, when tormented verbally, said “sticks and stones can break my bones, but words can never hurt me.” In truth, however, words are more harmful than all the sticks and stones thrown at us.

In order to manage change proactively, culture, not strategy, must be the focus of these change efforts in the future. Change is stressful, and is required for growth to occur. Without some kind of stress to the current state of affairs, people and by extension organizations will not change. Organizational cultures that are toxic place the health, welfare and survival of the company as the primary goal of the organization. This approach is at odds with the ethos of caregiving which is the central focus of all human services. It is this approach that results in toxic cultures where the focus is more on process than outcome.

Analysis

McClelland’s Theory of Motivation (McClelland & Burnham, 2003) provides a model to assess and identify the motivating factors of Power, Achievement, and Affiliation. In a beneficial culture, leadership staff whose primary motivation is power can use power to support affiliation and achievement. This support can identify points at which affiliation and achievement need more structure and a goal oriented focus. When there are conflicts between people who focus on relationships and those who focus on achievement, power can be used to manage conflict in a Win-Win style. In a culture where the behavioral styles of leadership are more toxic, power is used to coerce achievement and suppress affiliation. Organizational cultures are nothing more than

the ways in which people relate with each other in the workplace. These relationships are then codified into policies and procedures and become behavioural norms for people in the organization.

The US Army commissioned a study of why so many soldiers were committing suicide both during their tenure of service and after discharge. In a study led by David Matsuda, one of the common denominators among a majority of the soldiers who committed suicide was toxic leadership. Toxic leadership styles are now being studied by the Army War College and is being discussed in military sponsored websites (Vergun, 2015). Below is a chart comparing the symptoms of a toxic culture identified in the US military with their counterparts to create a beneficial culture:

Symptoms of a toxic culture	Symptoms of a beneficial culture
Micromanagement – while awareness of what people within the organization are doing is important, requiring constant updates and delaying decisions until all data is analyzed results in decisions that inhibit the creativity of subordinates.	Actively supportive management requires the leadership of a culture to be out and about, visibly participating in the activities of the organization. Information is analyzed using transparent metrics and communicated to all levels of the organization.
Lack of respect for subordinates – when directions are given to subordinates without words such as “please” or “thanks” this lack of respect adds to the stress levels resulting from micromanagement.	Respect is present not only on paper but in the day to day and hour to hour interactions between people. Whenever leaders respond, they do so in a way that enhances self esteem and build people up, rather than tearing them down
Zero tolerance policies – in many military cultures, the actions of one or two people result in punishment for the entire group. Expecting 100% compliance is humanly impossible, but 100% cooperation is possible. Cooperation requires a relationship, while compliance does not. Zero tolerance policies are ineffective and harm morale.	When mistakes occur, the focus is on making different decisions next time by learning from the past. Patterns of behaviors that result in mistakes are identified to change systems to support the people within the system. “What went wrong?” is the first question asked, not “whose fault is it?”
Risk-averse leadership – tradition for tradition’s sake is poor leadership. When change needs to be implemented, leaders who are averse to risk will demand that every option be assessed before a decision is made.	Risks and benefits are balanced with a clear need to maintain safety for all people. Safety management, not risk management, is the focus of the leadership and of all people within the organization.
Directions given without clear purpose – In the military culture, directions are given at the last minute, with no information on how the actions will lead to outcomes that are desired. Following orders becomes the only purpose.	All directions are tied to the purposes and goals of the organization. Tradition is honored and build upon, not worshipped.
No attempt to develop subordinates into leaders – developing new leaders is one of the key purposes of current leadership staff. When there is no clear methodology for this, and limited communication between lower and upper echelons, followers become stymied and lose their own sense of purpose and have lowered morale.	Developing new leaders is the primary responsibility of current leaders, according to the Harvard Business Review, Disney Institute, and other thought leaders. Managing the future is what leadership should do as management focuses on managing the present.
Power is centralized in upper management – non-commissioned officers (NCO’s also known as sergeants) have historically been the backbone of the US military. When NCO’s no longer have the authority to make field decisions but must get permission from their supervisors to engage in corrective actions with soldiers, trust is eroded and morale is again lowered.	The de-centralization of power is one of the critical elements of organizations that are able to adapt to changing environments. When every decision requires a meeting and a focus group, the ability to adapt and respond is diminished. Power to make decisions is balanced by diffusing the power among levels within the organization to enhance decision making. Ultimate decision making authority rests with leadership, with participation by followership members
Lack of trust at all levels – this is the result of the first 7 symptoms of a toxic culture, and is endemic within some command structures.	Trust is the result of the first seven items. The beneficial aspects of a culture are maintained and enhanced by trust which is continually renewed.

The symptoms of the toxic culture identified in the US military are similar in nature to the factors that lead to toxic cultures in healthcare settings. (Jones 2015) When they are balanced by the trust building actions identified in the right hand column in the chart above, organisations are able to adapt to and thrive in the changing environment of health care provision.

The first item noted in toxic leadership is micromanagement. Using McClelland’s model, micromanagement is Power without Affiliation. The toxicity within an organization often manifests itself in micromanagement. In a culture of care, using McClelland’s model, actively supportive management is the use of power to achieve a goal working with followers. The culture of the organization in which management is actively supportive is one in which followers are coached to succeed. (Valcour, 2014) management is power with affiliation, directed towards Achievement.

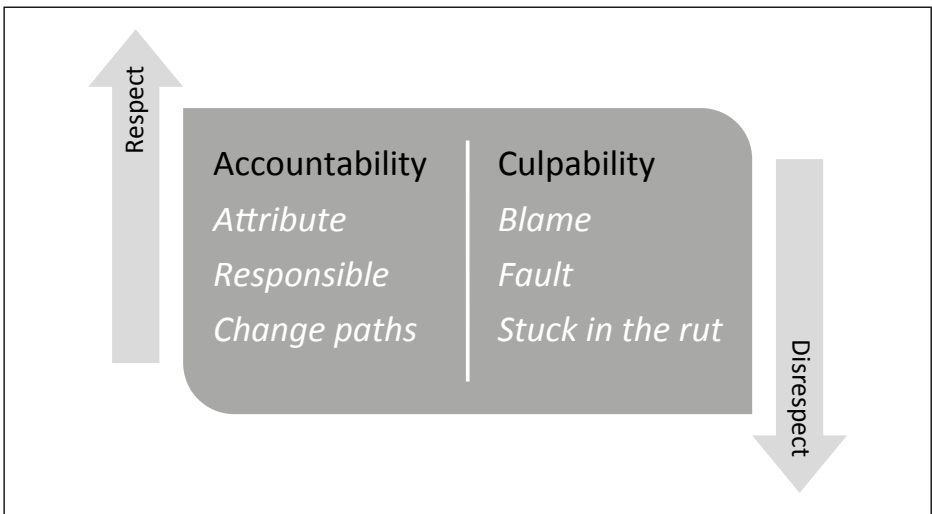
Leaders are often active, and what is needed is a combination of action and support to empower people to actively follow. In many organizational cultures, followers are expected to be passive and “follow the leader” rather than active participants in the process of achieving the goals of the organization.

The second item is lack of respect by leaders of subordinates. Respect is easier to teach than to define (Spagnoletti & Arnold, 2007) Lack of respect of subordinates by supervisors and managers has been well documented, and research shows half of employees feel disrespected by their bosses. (Porath, 2014) Employees are considered to be followers rather than leaders, and this passivity is expected by leaders.

This bias towards passivity is seen in definitions of what it means to be a follower. A willingness to accept direction and guidance from leaders in an organization. An employee who practices followship recognizes that any effective organization needs both leaders and followers. (businessdictionary, 2015). The practice of doing what other people suggest, rather than taking the lead. (collinsdictionary, 2015)

In order to build a culture of care, there must be actively supportive leadership and actively engaged followship. Leadership and followship must coexist in partnership in order for safety to be established at all levels of the organization.

The third area reviewed is that of Zero Tolerance Policies. Accountability must be present in all organizations in order for successful implementation of the work to be done. The difficulty is that many leaders confuse accountability and culpability.



A culture of culpability is one in which, during meetings, managers state that people should be fired for what they did, rather than discussing patterns of behavior that can be changed so the entire organization can learn from one mistake.

The 6th area identified in the study of military leaders was centralized power. The human tendency to see choices in binary pairs is known as either-or thinking. People believe that power should either be centralized or de-centralized, and have difficulty understanding how it can be both-and. Organizations are not democracies, and cannot be operated as such. But input in the decision making process is important, and the more input people have, the more they believe that they participated in the decision and the more ownership they will have.

Synopsis

Changing organizational cultures is difficult work and most of these efforts fail. (Kotter 1995, Kee & Newcomer, 2008). The primary reason is that the focus of such efforts is on what people do rather than what

people believe. Belief is the basis of behavior, and finding new ways to think about leadership and followship will result in new ways of behaving with and towards each other. Safety at emotional, psychological, and physical levels must be in place for all people within the organization so they can pass this safety on to others in human service settings.

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Learning objectives

Participants will...

1. be able to identify the three motivational styles suggested by David McClelland.
2. be able to delineate the ways in which these styles can become toxic and/or beneficial.
3. be able to understand their own unique motivational style.

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Working in Collaboration: Alternative methods of Preventing and Managing

Sub-theme: Creating aggression and violence minimizing cultures

Paper

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Keywords: Violence and Aggression, Proactive measures, Patient focused, Non punitive intent, Empowerment, Training, Least Restrictive interventions

Patient violence and aggression within UK psychiatry constitutes a significant problem, and consequently the prevention and management of the phenomena has become one of the largest practice development needs within such services (particularly in forensic settings). Figures published by NHS Protect (2015) for incidents of physical assaults towards NHS staff in 2014-15 record a figure of just under 68,000, with a large majority occurring within mental health and learning disability settings. Much of the literature on mental health nursing, particularly in secure services, describes the (sometimes conflicting) roles of the nurse in enabling patient choice and autonomy within safe environments and therapeutic relationships with defined boundaries.

However, aggression and associated fear within locked facilities can lead to coercive interventions such as disproportionate physical restraint, which “can be frightening and disempowering for anyone, let alone someone in a highly distressed state” (MIND, 2013, p3). Other recent publications describe uncaring and degrading treatment, together with inappropriate use of physical interventions within healthcare (D.O.H., 2014), and emphasise the need to reduce restrictive interventions.

Literature and our own experiences suggest that historically, aversive techniques were often used to manage patients’ aggressive behaviours once manifested - a reactive model imposed upon the situation and patient(s) involved. Management strategies included inappropriate and excessive use of seclusion and psychoactive medication. In addition, there was an emphasis in practice (and in the associated training) on “control and restraint” techniques, which caused pain to the patient via exertion of unnecessary force and pressure (usually to wrist joints). Some of these techniques were given labels which (perhaps unintentionally) suggested punitive intent, e.g. “locks” and “tweaks”.

At Arnold Lodge, a Medium Secure Unit in central England, we have developed and improved training in the care of individuals with aggressive and violent behaviours, ensuring it is strongly underpinned by the basic tenets of nursing. Our training, as advocated by the public health approach (World Health Organisation, 2002), is structured around ‘primary’ and ‘secondary’ strategies that emphasising a proactive and preventative model for violence and aggression. These include interrelated risk assessment and therapeutically engaging observation skills, to assist in early recognition of individual’s warning signs and individualised strategies to be employed to ameliorate distress and agitation. Therefore, there is a strong focus on nurturing the nurse-patient relationship, characterised by trust and approachability, thus enabling the patient not to ‘lose face’. Understanding the patient within a therapeutic relationship and creating individualised care via collaborative work with inpatients are cited as pivotal to both patient recovery (Mahoney et al, 2009) and aggression and violence reduction (D.O.H., 2014). This indicates to patients a desire to work with and not against them, in partnership instead of perpetuating attitudes indicative of a divisive and negative culture. However, the interpersonal relationship, identified by Cutcliffe & Happell (2009) as central to effective nursing practice, can often be difficult to achieve and maintain within forensic settings, (where limit setting, rules and a diminished sense of autonomy may lead to patient frustration and aggression).

Embedding evidence-based violence reduction models within training, in particular the primary and secondary strategies highlighted by both Colton (2004) & Huckshorn (2005) has appeared productive, with evidence of reduced incidents within our male mental illness acute/admissions ward. Our presentation will aim to discuss how changes to the environment and patient-focused structure have assisted in patient recovery, which in turn has led to a reduction in the use of physical (‘tertiary’) interventions. Furthermore, the influence of strong leadership has assisted in influencing cultural change and raising staff awareness in relation to reducing restrictive practices within clinical settings. Focussed staff support meetings have further embedded violence reduction principles, e.g. the use of effective verbal and non-verbal communication skills to assist in diffusing

an individual's hostility (NICE, 2015). This has created a well-balanced but safe environment in which staff can deliver nursing care and truly 'connect' with individuals, (as advocated by Delaney & Johnson, 2006).

However, not all attempts at diffusing a situation through primary and secondary measures are successful, therefore appropriate, safe and effective tertiary interventions for staff to employ are still necessary. These are taught to unit staff 'in-house' by the unit's Violence Reduction Department in a professional manner using a responsive course syllabus (Bowen et al, 2011) - (NB If our paper is accepted, aspects of our courses will be demonstrated or shown via video clips). Within courses, the need and means to rebuild the therapeutic relationship following physical interventions is highlighted, in order to minimise any resultant psychological harm or distress.

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Learning objectives

Participants will...

1. gain an understanding how primary and secondary strategies have assisted in reducing the need for restrictive practices and reinforce a caring culture.
2. gain an insight how a continuum of physical interventions attempts to maintain patients' rights and dignity.

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Dealing with aggressive behaviour in nursing homes: Nurses' use of strategies and interventions

Sub-theme: Creating aggression and violence minimizing cultures

Paper

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Keywords: Aggressive behaviour, nursing homes, strategies, measures

Background and context

Caregivers are confronted with a major challenge when faced with the aggressive behaviour of residents in nursing homes. Studies have demonstrated that nursing staff in geriatric wards experiences the third highest frequency of aggression after psychiatric and emergency wards. Researchers in this field agree that resident aggression has multifaceted causes. Therefore, they take into consideration several factors, such as resident-related factors, caregiver characteristics and competencies, and environmental aspects. The relation between dementia and aggressive behaviour is one of the most widely discussed aspects, whereas the relation between caregiver characteristics and environmental factors has been only sparsely investigated. People suffering from dementia are sensitive to changes in their environment. There is some evidence that caregivers with more clinical experience and a higher level of professional training use needs-based approaches more often to minimize aggression. A further aspect is caregivers' lack of time for appropriately supporting residents in activities of daily living. This results in a significantly higher proportion of physical assaults.

The interaction with people suffering from dementia and displaying aggression is described as a balancing act between contradictory positions, namely "meeting the person in my world" versus "her/his world", "feeling powerless" versus "capable", and "feeling rejected" versus "accepted". Yet, despite the well-known increase of people suffering from dementia and the expected increase of aggressive behavioural symptoms, aggression has been sparsely investigated in Swiss nursing homes. Therefore, this cross sectional survey addresses caregivers' experiences with resident aggression in nursing homes. It also investigates their strategies and measures for dealing with aggression. It is well known that they have to react quickly and to decide about appropriate interventions and strategies in these situations. Recommended measures refer to interventions in acute aggressive incidents as well as to long-range and preventive strategies.

Methodology

A cross-sectional survey with a total of 804 participants in 21 Swiss nursing homes, located in urban and rural regions in the German-speaking part of Switzerland provided insight into nurses' experiences and handling of residents' aggressive behaviour. Data collection was conducted in 2011 by the means of a questionnaire. The questionnaire consisted of the German version of the "Survey of Violence Experienced by Staff (SOVES-G)" and the "Resident Aggression Management Inventory (RAMI)" which based on published recommendations regarding the management of aggressive behaviour and amendments by experts.

Findings

The participating nursing homes varied in size between 25 and 705 beds. In seven nursing homes caregivers of one to three units took part, whereas in the remaining nursing homes all caregivers participated. In total, 1572 questionnaires were distributed and 814 returned. This resulted in a response rate of 51.8%, varying from 29.6% to 92.5% in the respective institutions. 10 of 814 questionnaires were invalid, so 804 questionnaires could be integrated into data analysis. 749 (93.2%) women and 50 men (6.2%) participated, 40% of them are registered nurses. Almost 25% of them have an education as enrolled nurses. More than 25% are working as nurse assistants.

Almost all participants (96%) experienced aggressive resident behaviour during their professional life. Approximately 80% reported about aggressive incidents during the last 12 months. Related to the period of the last seven working days, 307 participants (38.2%) were confronted with aggressive behaviour. Data about

the most impressive aggressive incident showed that participants were particularly confronted with verbal insults and physical attacks.

In acute aggressive incidents, the most widely used strategies were “reassuring conversation”, “keeping oneself at a distance from the aggressive person”, “leaving the room” and “request to change the behaviour”. “Calling for help”, “administering drugs” or “restraining the resident” were significantly less frequently used measures (Table 1).

Table 1: Short-term measures after aggressive behaviour of residents*

Rank	Short-term measures	Total	(n = 301)
		n	(%)
1	started reassuring conversation	167	(55.5)
2	distanced herself/himself from the aggressive resident	155	(51.5)
3	left the room	124	(41.2)
4	requested the resident to change behaviour	100	(33.2)
5	tried to hide her/his feelings	57	(18.9)
6	led the person to a quiet place	53	(17.6)
7	other measure	52	(17.3)
8	called for help	27	(9.0)
9	administered drugs	25	(8.3)
10	retained the resident, using physical force	19	(6.3)

*Multiple answers possible

More long-range and preventive measures referred to “searching for reasons of aggressive behaviour”, “performing interdisciplinary case discussions”, “taking the resident’s perspective to understand the meaning of the behaviour”, “integrating biographical information”, and “finding out underlying physical reasons for aggressive behaviour”. Roughly 80% stated that they describe aggressive behaviour in the nursing report or in an aggression protocol. Around 75% applied measures for validation and always or frequently adapted the daily structure to residents’ needs.

Cluster analysis was used to classify caregivers into groups according to their answer to suggested measures. Two well differentiated clusters were identified. The two groups did not differ in terms of the measures they use, but with respect to the frequency of application of these measures. In a next step, a multiple regression analysis was conducted to identify characteristics encouraging the use of the recommended measures.

Caregivers with an employment level of over 80% apply the recommended measures significantly more often. This is also the case among caregivers who receive support from superiors and when institutionalised assistance for affected caregivers is available. Caregivers who do not know if their institution has a reporting system for aggressive incidents apply recommended measures significantly more frequently than those in institutions without a reporting system. Further, caregivers’ judgement about the importance of training in aggression management seems to be a predicting factor for their application of recommended measures as well as caregiver’s confidence in managing aggressive behaviour.

Finally, there is an interaction between caregivers’ perceived competence in empathising with residents’ perspective and their professional experience in health care. For caregivers with less professional experience, competence in empathising with residents’ perspective has no influence on applying recommended measures. However, there is a positive relationship between competence in empathising with residents’ perspective and applying recommended measures for caregivers with more than nine years of professional experience.

Discussion

The results of our study regarding caregivers’ strategies for dealing with resident aggression refer, on the one hand, to measures caregivers use in situations of acute aggression and, on the other hand, to general measures with a more preventive intention.

In situations of acute aggression caregivers primarily intend to de-escalate the situation by means of a conversation. Restrictive measures, e.g. restraint, are used significantly less often. Frequently “leaving the room” was mentioned as a short-term measure with the intention to achieve a calming effect on the resident and to continue with nursing interventions after a certain time. Based on the assumption that aggressive behaviour is a way to express or communicate needs, it might be problematic if caregivers leave the room. The needs-based behavioural model assumes that every behaviour has a cause and it should be directive for caregivers to identify the underlying cause of behaviour.

General measures with a more preventive intention focused on taking the residents’ perspective to understand the meaning underlying aggression and to integrate biographical information. These results indicate that participating caregivers endeavoured to gain insight into the resident’s world with the aim of understanding his or her behaviour. In a framework of optimal therapeutic interventions for managing verbal and behavioural aggression among patients with dementia, “entering in the resident’s world” is described as an important measure within the scope of patient-centred care. Caregivers are encouraged to become a part of the resident’s lived experience and to strive for mutual understanding and action.

Participants differ significantly in the frequency of applying recommended measures. Support from superiors and assistance for affected nurses positively influences their use of measures. Findings show the importance of support from superiors and institutionalised assistance for affected nurses. Caregivers who felt supported by colleagues and the management described their work as stimulating and challenging despite the fact that aggressive behaviour could occur. They felt that they worked in an innovative climate and continuously exchanged their experiences concerning the care of affected residents and supported each other. Furthermore, competence in empathising with the residents’ perspective is important for using person-centred approaches in the care of residents with aggressive behaviour.

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Learning objectives

Participants will...

1. have an understanding about the type of measures nurses use in dealing with resident aggression in nursing homes.
2. identify factors that encourage the use of recommended measures in dealing with resident aggression in nursing homes.

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Guiding Organizations Towards Wellness: Identifying and Transitioning Toxic Organizational Cultures to Support Minimizing Restraint

Sub-theme: Creating aggression and violence minimizing cultures

Workshop

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Keywords: Toxic Cultures, Wellness, Minimizing Restraint

Abstract

Research data from Harvard Business Review, Forbes, Dr. John Kotter and others point out that 70% of organizational culture change efforts fail. Dr. Kotter, one of the foremost experts in organizational change theory, states that only 5% of organizations meet or exceed the goals set for organizational change. A search of LinkedIn found over 66,000 positions for organizational consultants, and more will probably be hired because of the high failure rate in the field of organizational culture change efforts.

They fail for a variety of reasons, but chief among them is toxic leadership and the toxic cultures associated with leadership. It must also be recognized that followship can be just as toxic and just as damaging as leadership. Followers can be just as prone to negative interactions as leaders, but it is often the followers who pay a price. In a study of leaders and followers, when toxic behaviors come to the attention of managers, administrators, and the Board of Directors, it is more often than not that the followers are disciplined or terminated from employment, not the leaders. In these toxic cultures there are different standards applied for accountability.

This workshop will explore the relationship between McClellan's X-Y theory of motivation and the three behavioral components in the theory. Power, Achievement, and Affiliation interact with each other and with the needs of the stakeholders within the context of the situation. Each of these three motivational factors are present in most, if not all workplace interactions. Understanding how to use Affiliation, Achievement, and Power in beneficial and not toxic ways is crucial to building cultures which minimize the use of restraint, seclusion, and other restrictive practices.

Understanding the toxic and coercive nature that is present when Power is misused helps to frame the misuse of restraint. Identifying how coercion can turn Affiliation into manipulation helps to understand how staff can manipulate individuals served because they themselves are manipulated. When Achievement is misused, process is valued over outcomes and if the paperwork is correct, the outcomes are assumed to be correct as well.

Power, achievement and affiliation are all necessary constructs for organizational success. When organizational cultures get the balance right, they are able to successfully navigate the constantly changing landscape of the health care system. Problems arise when people within organizations engage in toxic variants of these motivational styles of interacting.

The roles of Leadership and Followship are central to the beneficial variants of Power, Achievement, and Affiliation. Kruse's definition of leadership is 'a process of social influence which maximizes the efforts of others towards the achievement of a goal. The authors define Followship as a process of social influence which maximizes the efforts of leaders towards the achievement of a goal.' By identifying the toxic and beneficial variants of Power, Achievement, and Affiliation, organizations can empower and support staff so they can in turn support individuals served to achieve a high quality of life.

Learning objectives

Participants will be able to...

1. identify the toxic variants of power, achievement, and affiliation.
2. demonstrate examples of the beneficial aspects of power, achievement, and affiliation.

3. list the elements of healthy workplace cultures.
4. differentiate between leadership and followship.

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Interventions during aggressive behaviour on an acute psychiatric ward: A descriptive quantitative case study that evaluates which interventions of 'The Crisis Monitor' might affect the score on the Kennedy Axis V

Sub-theme: The minimization/reduction of seclusion, restraint and coercive measures

Poster

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Keywords: Aggressive behaviour, risk-management, acute psychiatric ward, Crisis Monitor, short-term structured risk assessment, loss of control

Background

Patients can be admitted to an acute psychiatric ward due to various reasons. These admissions can be caused due to a risk of self harm and/or being a potential threat to others. Such risks may manifest in extreme confusion. Losing self-control is often related to severe incidents which may result in seclusion and restraint. These measures are primarily used as the last method of crisis-intervention.

The Crisis Monitor is a short-term structured risk assessment, invented in The Netherlands by Roland van de Sande. Short-term risk assessments are presumed to reduce incidents including aggression and seclusion on acute psychiatric wards. Nowadays this instrument is often used within wards across the country.

Within The Crisis Monitor the Kennedy Axis V scale is an indispensable element. This scale is used to identify the risks of loss of control that might result in escalations on the ward. Several studies show positive outcomes on the use of The Crisis Monitor. The implementation of this instrument has proven to reduce the number of aggressive incidents and time in seclusion for patients admitted to acute psychiatric wards. Yet it remains unclear which specific interventions from The Crisis Monitor cause the decrease in aggressive incidents and/or seclusion and restraint.

Aims

The aim of this study is to reveal which interventions, when applied on patients, may affect the outcome of the Kennedy As V score. These outcomes could function as evidence based practice and might reduce the number of aggressive incidents and time in seclusion.

Method

A retrospective case-study was conducted on the files of patients from a Dutch ward. This research was done over a 16-week period to evaluate their scores on the Kennedy Axis V during 2 weeks of their admission. Using the first day of their admission as the starting-point and taking the final measurement 14 days later. This case-study tries to show the influence of used interventions on the Kennedy Axis V score within this time span, whilst taking in account the characteristics of the individuals. Several statistical tests were taken and applied in SPSS.

Results and Conclusion

All patients (n=105) over a period of two weeks during 2013 and 2014 were evaluated by the methodology as described before. The total group of patients was divided in two groups. The interventions 'rest' and 'use of sedatives' were applied more to the patients with schizophrenia than to the restgroup. The interventions 'offer an activity', 'a conversation offered by a nurse' and 'restrictive measures' were applied the most. Only the intervention 'restrictive measures' showed a significant consistency with one item on the Kennedy Axis V scale. Aggressive behaviour seemed to be the main reason to precede admission on an acute psychiatric ward.

Learning objectives

Participants will...

1. have an understanding of the use of the short-term structured risk assessment the Crisis monitor, used on an acute psychiatric ward in Utrecht/The Netherlands.
2. have an understanding of witch interventions from the Crisis monitor were applied the most by nurses and witch interventions show a significant consistency with one item on the Kennedy Axis V scale.

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Work place violence in nursing

Sub-theme: The minimization/reduction of seclusion, restraint and coercive measures

Poster

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Keywords: Violence, Nursing, Depression, Anxiety

Abstract

Violence against nurses is a complex and persistent occupational hazard facing the nursing profession. Paradoxically, the job sector with the mission to care for people appears to be at the highest risk of workplace violence. Nurses are among the most assaulted workers in Health Care industry. Too frequently, nurses are exposed to violence – primarily from patients, patients’ families, visitors, and Health care team members too. This violence can take the form of intimidation, harassment, stalking, beatings, stabbings, shootings, and other forms of assault.

Psychological consequences resulting from violence may include fear, frustration, lack of trust in hospital administration, and decreased job satisfaction. Incidences of violence early in nurses’ careers are particularly problematic as nurses can become disillusioned with their profession. Violence not only affects nurses’ perspectives of the profession, but it also undermines recruitment and retention efforts which, in a time of a pervasive nursing shortage, threaten patient care.

Learning objectives

Participants will...

1. become aware of the problems of violence against nurses in this part of India.
2. learn of different methods and solutions to stop the work place violence for quality care and safety of patients and nurses in the work place.

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Nurses' Information, Attitude and Practices About Physical Restraint in Turkey: A Systematic Review

Sub-theme: The minimization/reduction of seclusion, restraint and coercive measures

Poster

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Keywords: Physical restraint, nursing, nurse, Turkey

Background and Context

Physical restraint is defined “commonly as any device, material, or equipment attached to or near a person’s body that could not be controlled or easily removed by a patient and that deliberately prevents or is intended to prevent free body movement to a position of choice or a patient’s normal access to their body” (Retsas 1998).

Physical restraints have been widely used in hospitals to avoid a range of difficult clinical situations, especially during acute care. They are used to save patients and their relatives from inflicting any harm to themselves, such as to prevent patients with confusion or dementia from either falling from beds, removing tubes, drains, and medical equipment from their bodies, causing harm to themselves, and to ease control of patients (Bower and McCullough 2000). Especially in psychiatry clinics, physical restraint is used to handle violent and maladaptive behaviors, manage patients with severe mental disorders, prevent injury and reduce agitation and aggression (McCue *et al.* 2004; Chien *et al.* 2005).

Nurses are most intimately involved in the decision to restrain and in its implementation. Therefore, it is important for nurses who exclusively providing general health care, be knowledgeable about physical restraint, so that they can perform with best possible attitude and methods for their patients.

Within this context, this study was held with the aim of reviewing studies about nurses’ information, attitude and practices against physical restraint applications in Turkey and systematically analysing data obtained from the studies. Therefore, the main question of “What are nurses’ information, attitude and practice status about physical restraint in Turkey?” will be sought an answer.

Methodology

This study was conducted by means of a systematic review of the databases including CINAHL, Pubmed, Medline, Scopus, Ebsco Discovery Service, Science Direct, ULAKBİM and Google Scholar. Relevant articles from past (without date restriction) to 2016 were retrospectively will be extracted without date restriction. The keywords are “physical restraint”, “nurse”, “nursing” and “Turkey”.

Inclusion Criteria for Systematic Review

1. The full text of studies to be accessible.
2. Studies that published in national and international journals in English and Turkish language.
3. Original and quantitative studies.

Findings

Data extraction is still ongoing in detailed style by principal authors. Description of studies and the key findings will be presented.

Implications for practice, research, education & training, organisation / management, policy and guidance

1. It is thought to be beneficial to create a profile for those nurses providing general healthcare about 1) the prevalence of their using physical restraint, 2) the reasons for the usage of physical restraint, and 3) the

types of physical restraint usage, along with their knowledge of how to use it and their attitude while they are using it.

2. It gives an opportunity to provide evidence-based information about the usage of physical restraint in general healthcare.
3. It allows to argue about the advantages of the physical restraint practices on medical treatment and nursing care maintenance, preventing patient self-harm against real violence or threats of violence, protecting other patients and healthcare team against damage.
4. And it is targeted that, this systematic review will contribute to the preparations of in-service education programs in healthcare areas and practices related to the topic in health sector.

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Learning Objectives

Participants will...

1. be able to compare the usage of physical restraint in general healthcare internationally.
2. have increased information about the usage of physical restraint in general healthcare.
3. be able to evaluate the effectiveness of physical restraint methods in general healthcare, which include maintaining continuous medical treatment and nursing care, protection patients from accidental injury and protection of other patients and staff from harm.
4. have an understanding of attitudes and practices of nurses' who work different clinical services about physical restraint in Turkey.

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Sensory modulation used as a direct care response to decrease agitation in the acute psychiatric setting

Sub-theme: The minimization/reduction of seclusion, restraint and coercive measures

Poster

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Keywords: Acute psychiatry, Mechanical restraint, Agitation, Sensory modulation, Deescalation, Arousal

Background

Due to an increased focus on reducing coercion in Denmark and an international criticism of mechanical restraint, Psychiatric Center of Copenhagen want do address and change the culture on how to deal with coercion in the Danish health care system. International inspiration lead to multiple alternative interventions in the care of psychiatric patients. The acute ward chose to go forward with the implementation of a sensory modulation room. Sensory modulation is used as an effective way of deescalating agitation, by stimulating the patients senses with the purpose of lowering the level of arouse. Sensory modulation is based on a unconsciously level and builds upon the principle of "let the sensory stimulation do the work" - opposite to conversion, which is based on a conscious level.

The process

A workgroup was established November 2013 which lead to final project outcast June 2014. The cost was 55.000 € before the opening date in May 2015. The result was a highly modern sensory modulation room including foam-padded wall, beanbag chair, subwoofer music madras, integrated spotlights and I pad unit which allows control of relaxation music and films projected to a large screen.

Goal

The use of the room should help patients whom are in a state of agitation that requires a direct care response in terms of shielding and/or active control of stimulation. The acute ward seeks to Decrease mechanical restraints, prevent episodes of violence, support psychotropic synergy effect and decrease the use of PRN and support the patient in coping with the acute psychiatric symptoms.

Results

The patients were scored on the Brøset Violence Checklist. The mean BVC score was 2 prior to use of the room, which indicated a potential high risk of violence. After use of the room the mean BVC was 0 which indicated highly effect in terms of reducing the risk of violence. At the same time, the patients scored themselves using a VAS score, and overall they experienced high/very high effect in the use of the different sensory equipment.

Conclusion

In 2014 the acute ward had 188 episodes of mechanical restraint. In 2015 the number of episodes where reduced to 98. The reduction is a result of a massive change of culture. As part of the culture change, the acute ward, not only introduced the sensory modulation room. As a parallel intervention, the ward reestablished the nursing office by removing all chairs from the office. Creating a standing office environment supports the idea of a limited time spent in the office, and thereby breaking down barriers between staff and patients. The result is that the staff is visible and accessible at all time for the patients, with the opportunity of timely response to e.g. conflicts and agitation. Increased staff accessibility combined with the use of sensory modulation, as a way of responding to aggressive behavior, have indeed contributed to a significant reduction in mechanical restraints in the acute psychiatric setting.

Learning objectives

Participants will...

1. have an understanding of the principles of sensory modulation.
2. Appreciate the first results of the pilot study.

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Restrictive Practice: De-mystifying the principles to support implementation

Sub-theme: The minimization/reduction of seclusion, restraint and coercive measures

Workshop

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Keywords: Reducing restrictive interventions, Frontline staff survey, Knowledge affecting practice

Violence and aggression has been one of the most significant risks in inpatient psychiatry settings competing only with self-harm. Organisations have historically been over-reliant on the use of physical interventions to ameliorate this problem even though evidence suggests that not only is this method predominantly reactive; it also increases the likelihood of causing injury, affects therapeutic relationships, increases frustration and burnout and is likely to delay the recovery process. Although we are aware that restrictive practices stretch far beyond physical restraint and seclusion encompassing a wide range of activities - some deliberate and some less so; media coverage has led to increased scrutiny, pressure to act, a level of moral panic and a renewed drive for reducing the use of restrictive practices with some statutory, regulatory, voluntary and professional bodies calling for a ban on particular techniques, understandably, in a bid to promote safe and therapeutic environments for patients to recover and staff to work in. Simply defined, restrictive practice is *"making someone do something they don't want to do or stopping someone doing something they want to do"*. (Skills for Care & Skills for Health, 2014)

There is however evidence of limited understanding of the meaning of restrictive practice and its implementation at the coalface despite the expectation that staff are to intervene in the 'least restrictive' way possible. To some extent this remains an enigma because there is limited research available on the subject and a high number of emotive rather than informative and academic pieces written. That said, there is the knowledge that restrictive practices such as unnecessary control of access to outside areas, drink and meal times, sleeping times, property and other blanket restrictions is one of multiple factors that can lead to patients presenting with aggressive and/or violent behaviour. Some restrictive practices are necessary to manage risk and indeed some are statutory however it must not be ignored that those same restrictions also increase frustration, disempowerment, flash points, opportunity for confrontation and even abuse/over-use. Unnecessary restrictive interventions are still being widely used in inpatient settings across the UK, worryingly by professionals whose Code of Practice and national guidance not only emphasises on individualised based recovery approach but also the use of 'least restrictive' practices.

Reports suggest that there is the need for a better understanding of restrictive practices from 'board to ward' and for the changes in practice to be a whole service approach owned and led from the top. The Care Quality Commission (CQC) after a visit to 150 inpatient psychiatric units in 2011/12 highlighted that these practices were being used by staff mostly because they were part of 'the policy' or 'rules'. The CQC returned to these services between December and March 2013 to carry out another short survey and found that wards were imposing a lot of blanket restrictions that go against the human rights of patients.

A number of recent studies have noted that it is possible to significantly reduce restrictive practices. A review conducted by the Irish Mental Health Commission in 2012 found that there are 9 main components in programmes that deal with the reduction of restrictive practices. Government level support in the UK has been evident given the recent policy and regulation changes that focus on the need for the use of least restrictive options, the change in the CQC inspection regime and the focus on least restrictive practices. Patients, their families and carers and the voluntary sector have been involved in the changes at policy level and been informed of their rights and what they should expect from services leaving the onus on health care providers to continue with their restrictive practice reduction strategies.

Statutory requirements have forced health care leaders to put this high on their executive agendas however thus far very little has been done to support staff on their knowledge of restrictive practice in general and how to implement it in their environment by addressing the underlying issues that could be creating confusion. The question has to be asked; why would caring professionals who are promoting wellbeing and recovery knowingly engage in practices that will go against their professional ethics and codes of practice?

Would they intentionally engage in practices that they are well aware would increase the likelihood of an assault or lead to restraint, seclusion or other restrictive practices?

To answer these questions we conducted a random survey of frontline staff who are the main people faced with making decisions about restrictive practices on a day to day basis. We found that there were gaps in knowledge and understanding of what constitutes restrictive practice therefore making it difficult if not impossible for them to choose least restrictive options. In addition to this, some staff were still unclear about ward rules and/or procedures which creates a confusion as to when they should restrict or not and if they have cause to restrict, to what level they do this. Although knowledge does not necessarily affect behaviour, there is some evidence to suggest that it can affect self-confidence or self-efficacy; improved performance can therefore be assumed to follow (Needham et al, 2005; Nau et al, 2009).

Following the findings from the questionnaire we ran a restrictive practice awareness campaign with the aim of raising the profile of and understanding of this concept. This included theory based workshops drawing on relevant publications. A thorough audit/evaluation of each service looking into any procedures and blanket rules against the risks for which it was put in place to address was completed. More in-depth workshops specifically designed for PMVA instructors who drive the least restrictive option agenda in their respective areas of practice were run. In addition to this we modified scenario based learning sessions in our PMVA syllabus to include the decision making process so as to better support staff understanding in making the decisions in practice rather than focusing largely on the physical restraint techniques. Following the preliminary work, the survey was repeated and evidenced a marked improvement in staff understanding which in turn had a positive impact on preventing and reducing violence and aggression. With improved understanding, frontline staff 'bought into' the idea of reducing restrictive practice rather than doing things because they were told to. As we know, change that occurs in this manner is that of driving and restraining forces pushing against each other thus leaving the change state in static equilibrium. Any change that happens in these circumstances is seen as negative and staff are likely to return to old ways of working. A joint strategy plan was drawn up and rolled out to support and sustain the changes taking into consideration research and best practice in the field of reducing restrictive interventions.

Although this is a working progress and we recognise that change is a process and therefore takes time; preliminary observations have shown that the above actions have affected the implementation of least restrictive practices positively. It is fair to say; blindingly obvious perhaps, that reducing the use of restrictive interventions and practices cannot be achieved without first addressing staff's knowledge about its principles as implementation requires a consideration of multiple factors for each patient as an individual. This is not information that can be clearly mapped out in a policy document for all to follow without thought.

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Learning objectives

Participants will...

1. appreciate the power of basic knowledge needed by frontline staff in order to reduce restrictive practice.
2. have an understanding of steps taken to reduce restrictive interventions during the first year a new strategy was implemented.

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Development of the MR-CRAS (Mechanical Restraint – Confounding-Risk-Alliance-Score) and validation among forensic psychiatric staff and experts

Sub-theme: The minimization/reduction of seclusion, restraint and coercive measures

Poster

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Keywords: Risk assessment, Mechanical Restraint

Background

The duration of mechanical restraint (MR) is particularly prolonged among forensic psychiatric inpatients. Use of a risk assessment instrument during use of coercive measures has shown promising results in reducing the duration. However, no instruments exist for use during MR to support the clinical decision-making among staff on whether the patient are ready to be loosened from MR with the aim of reducing the duration of MR.

Purpose

This project focus on developing a short-term risk assessment instrument: Mechanical Restraint - Confounding-Risk-Alliance-Score (MR-CRAS), and validating its measurement properties among experts and forensic psychiatric staff.

Design

Phase 1 served to develop a version of the MR-CRAS instrument through a methodological, theoretical and empirically conceptualization based on existing literature, content of a selected sample of risk assessment instruments as well as data from focus Group interviews among clinical experts with rich first-hand experience in MR. Phase 2 served to pre-evaluate MR-CRAS through 1) face validation among clinical experts within forensic psychiatry; 2) content validation of the items in MR-CRAS by a purposively sampled panel of researchers and clinical experts within the field; 3) Pilot testing of the instrument among staff within two forensic psychiatric inpatient units. Phase 3 serves to evaluate further measurement properties of the MR-CRAS instrument through a multicenter descriptive correlation study among staff within 16 forensic psychiatric inpatient units during a period of one year. The purpose is to gain insight into the dimensionality and functionality of MR-CRAS and deciding on the definitive selection of items through relevant analysis.

Results

Phase 3 is currently being undertaken but the results will be available at the presentation.

Implications

The results will provide a foundation for further testing of the reliability, predictive validity etc. of the MR-CRAS and for implementing the MR-CRAS as a valid and reliable risk assessment instrument during MR. The results will also open for validation and implementation in other psychiatric settings where MR is used, both nationally and internationally. In future clinical practice, MR-CRAS as a short-term structured risk assessment scheme could be an effective element in a SPJ approach during MR. Use of MR-CRAS in a structured professional judgement process would promote systematic and transparent risk assessment, yet be flexible enough to account for case-specific influences and the context in which the assessment are made. MR-CRAS will expand the traditional preventive use of short-term risk assessment with a unique framework for use during MR.

Learning objectives

Participants will...

1. realize that when Mechanical Restraint are used as a last option the duration of MR should be kept at a minimum.
2. become acquainted with the new risk assessment instrument (MR-CRAS) under development which aims to support healthcare staffs clinical desicion on when the patient is ready to be released or not from MR with the aim of minimizing the duration as soon as safely possible.

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Exclusion by seclusion – Influence of care workers on seclusion and patients' advice on prevention

Sub-theme: The minimization/reduction of seclusion, restraint and coercive measures

Paper

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Keywords: Coercion, aggression, clinical psychiatry, seclusion, patients' advice

Background

One of the great challenges of today's mental health care is to create a safe environment for inpatients and staff members. Seclusion and other coercive measures are used when no other (non-restraining) intervention is sufficient to restore the wards' safety. However, seclusion is an intervention with great risk of unintentional damage to the patient. Critical assessment of the amount of danger and making the decision to use coercion is a complicated process. Nurses' assessment of risk is critical for the decision if coercion is necessary and which type of coercion is legitimate.

Aims

In our pilot EXclusion by SEclusion (EXCEL)-study we: 1) Explore predictors in the nursing staff on aggressive incidents and the use of seclusion. 2) Investigate the association of nursing team dynamics and individual personality traits of nurses with aggressive incidents and the use of seclusion. As part of the Patient Advice on intensive care Unit Safety and de-Escalation (PAUSE) study we measure the perspective of the patient and the caregiver on the cause of the incident whether they can advise the nursing staff to prevent aggressive incidents.

Method

The study consists of two major components. The first component is a highly detailed observational study on a closed admission ward to find predictors in nursing staff- and unit characteristics for aggression and coercion. We collected data for two years in every shift (three times a day). The possible predictors included nurses' demographics, patient-staff ratio, environmental factors and nursing group interaction. The second component is the qualitative assessment of influencing factors on aggression and coercion. We perform a web-based explorative study to determine the influence of nurses' personality traits on the decision to use seclusion. We use logistic regression analysis to determine the association between personality traits and the decision to use seclusion. In the qualitative PAUSE-study, we analyse aggressive incident by interviewing the patient and the caretaker. Two researchers expressed all interviews by open coding and these concepts are transformed into categories by axial coding.

Findings

We found associations between seclusion and female gender, OR = 5.27 (0.98 – 28.49), and nurses' large physical stature, OR = 0.21 (0.06 – 0.72). We found that physical stature is the most substantial (although non-significant) factor: OR_{adjusted} = 0.27 (0.07 – 1.04). We expect the results of our final analysis by the autumn of 2016. We expect our results from the second component of our project (the PAUSE-study) by the end of 2017.

Implication for clinical practice

To prevent aggressive incidents, we must consider all aspects of aggression, including the interaction between patients and staff members. Although some evidence shows patient predictors of aggression, there is little evidence on the influence of nursing staff factors on seclusion and no evidence for the influence of nurses' personality traits on aggression in mental health care. We believe that further investigation of this construct is needed so giving us tools to take the next step in better interaction between patients and nurses.

Learning objectives

Participants will...

1. be able to reproduce the current level of scientific knowledge on the influence of nurses on aggression, violence and coercion.
2. be able to explain the importance of patients' advice for the prevention of coercive measures.

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A literature review and thematic analysis of psychiatric patients' perceptions of situations connected with coercive measures

Sub-theme: The minimization/reduction of seclusion, restraint and coercive measures

Poster

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Keywords: Coercive measures, Patient perceptions, Psychiatry, Systematic literature review, Aggression, Violence

Background

Coercive measures are widely used in psychiatric settings, but a Cochrane review shows no strong evidence for any positive effects of coercive measures. Furthermore, serious physical and mental consequences are reported from the use of coercive measures. This argues for an international request to reduce the use of coercive measures in psychiatric settings and to improve clinical practice on this specific area. In order to understand how this can be achieved, we also need to gain knowledge about the use of coercive measures from the patients' perspectives. Research suggests that psychiatric patients' experiences and perceptions of coercion is a longitudinal and coherent process, starting before and ending after the coercion. However, only a minor part of research within the area examines perceptions of coercive measures as a coherent process, explicit. Therefore, and in order to serve as a foundation for further research and development, a literature review that investigates psychiatric patients' perceptions of coercion as a coherent process was conducted.

Aim

The aim of this systematic literature review was to investigate what characterises research literature about adult psychiatric patient's reported perceptions of situations leading up to, during and leading after the use of coercive measures and their perspectives on what can reduce use and duration of coercive measures.

Methodology

A structured literature search in CINAHL, Pubmed, Embase and PsycINFO was conducted and spanned literature published between 2000 and 2015. The literature search resulted in a total of 24 included qualitative studies concerning psychiatric patients' perceptions of situations connected with seclusion, mechanical restraint, psychical restraint/holding and/or forced medication. The studies were analysed using a thematic analysis which draws on the methodological approach of Symbolic Interactionism.

Findings

The key findings are presented in themes and subthemes according to the natural timeline of situations connected with the use of coercive measures (situations leading up to, during and leading after the use of coercive measures). The main theme is characterised by the feeling of "Mental Pain".

Implications

The results of this systematic review are an important contribution to the on-going research and initiatives on reduction of coercion in psychiatric settings. Furthermore, this knowledge can be used to improve clinical practice in relation to the use of coercion.

Learning objectives

Participants will...

1. have an understanding of what characterises research literature about adult psychiatric patient's reported perceptions of situations leading up to, during and leading after the use of seclusion, mechanical restraint, psychical restraint/holding and/or forced medication.

2. have an understanding of what characterises research literature about adult psychiatric patient's reported perspectives on what can reduce use and duration of seclusion, mechanical restraint, psychical restraint/holding and/or forced medication.

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Principles supporting effective use of de-escalation techniques for the management of violence and aggression: patient perspectives

Sub-theme: The minimization/reduction of seclusion, restraint and coercive measures

Paper

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Keywords: De-escalation techniques, patient views

Background

De-escalation techniques aim to arrest the trajectory of aggression to violence through a range of psychosocial techniques, thus, avoiding use of potentially harmful coercive measures. As such, they feature prominently in international violence and aggression management policy. However, the qualitative literature describing best practice in relation to the techniques has some important potential limitations. Firstly, a relative lack of coverage of patient views and, secondly, the preponderance of studies involving mental health professionals interviewing other professionals (often those pre-identified as excellent de-escalators) for their views on the techniques. As such, the current evidence may not provide a full insight into patient experience of the techniques in routine practice. This study aimed to address these evidence-gaps in two ways. Firstly, to interview a broad sample of mental health in-patients and, secondly, to adopt a patient and public involvement approach to the study.

Methodology

Framework Analysis of qualitative interviews with a purposive sample of 26 mental health in-patients. A paid service user and carer advisory group assisted the project from the funding application to writing the final report. Analysis was co-produced with three paid service user researchers.

Findings

Participant accounts revealed a range of non-coercive interventions perceived effective in de-escalating aggressive behaviour. However, they also presented a widespread view that nurses routinely fail to use de-escalation techniques in response to aggression, with widespread first line use of physical restraint and coerced intramuscular medication commonly reported. Six principles supporting greater use and effectiveness of de-escalation techniques were identified, including: justice (the extent interventions are informed by justice); autonomy (the extent the patient is permitted to draw on their own resources to regain self-control); authenticity (the extent staff behaviour is perceived consistent with their true intentions and other thoughts and feelings); kindness and consideration; self-regulation and, finally, respect and equality. Individual staff and environmental factors that violated each principle were also identified.

Implications

Despite considerable recent focus on this issue, the problem of overuse of restrictive practises in mental health settings remains an enduring one. The six principles identified by participants reveal some potentially important avenues through which greater use and effectiveness of de-escalation techniques may be promoted.

Learning objectives

Participants will...

1. develop knowledge of patient perspectives on effective use of de-escalation techniques.
2. gain awareness of 6 principles perceived necessary for individual staff and clinical environment to adhere to in order to promote greater use and effectiveness of de-escalation techniques.

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The de-escalation continuum: a qualitative investigation of mental health staff perspectives on the use of de-escalation techniques for the management of violence and aggression

Sub-theme: The minimization/reduction of seclusion, restraint and coercive measures

Paper

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Keywords: De-escalation techniques, staff views

Background

De-escalation techniques represent a range of psychosocial techniques aimed at halting the trajectory of aggression to violence at the escalation phase. Despite featuring prominently in international violence and aggression management and training policy, there is little evidence of a positive impact on routine practice, where physical restraint, despite its known harms, remains an enduring feature. The evidence-base for the effectiveness of de-escalation techniques is limited, with no known randomised controlled trials evaluating their effects. A relatively small number of qualitative studies describing best practice exist, although they have tended to use small samples and often select participants identified by colleagues as excellent de-escalators, potentially reducing transferability of findings to routine practice. This study, therefore, aimed to investigate mental health staff perspectives on use of de-escalation techniques in an, arguably, more representative sample than has previously been achieved.

Methodology

Framework Analysis of qualitative interviews with a purposive sample of 20 mental health staff. The interview schedules were theoretically informed to the extent that they assumed that use and effectiveness of de-escalation techniques may be influenced at the level of individual staff, patients, clinical environments and the broader organisation.

Findings

Participant accounts revealed a continuum of interventions between those characterised as supportive (for example, reassurance, distraction, problem identification and solution-finding) and those characterised as controlling (for example use of reprimands, instructions, deterrents and containment interventions such as physical restraint and seclusion). In total 14 distinct intervention components across this continuum were identified.

Factors influencing decisions as to where staff chose to intervene along the continuum were wide-ranging and included: risk of violence; trial-and-error; knowledge of the patient; moral judgements about the function of the aggression; anxiety over potential contagion of aggression and, finally, local rituals and routines surrounding the management of aggression. Where routine use of containment interventions in place of de-escalation techniques was reported this was strongly linked with inadequate organisational resourcing exacerbating staff anxiety over the potential for contagion of aggression. There was a tendency for younger participants to advocate more controlling interventions and to select interventions on the basis of trial-and-error.

Implications

The cognitive and affective influences on staff decision-making in terms of the nature and timing of interventions they selected, reveal potential avenues through which to promote greater use and effectiveness of de-escalation techniques.

Learning objectives

Participants will...

1. gain knowledge of a continuum of interventions used in response to escalating aggression.
2. understand the range of staff, patient, environmental factors that appear to influence where staff intervene along the continuum of interventions.

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Do Politicians Have the Power and Ability to Order a Halving of Psychiatric Patients Experiencing Mechanical Restraints?

Sub-theme: The minimization/reduction of seclusion, restraint and coercive measures

Paper

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Keywords: Mental health, psychiatry, coercion, mechanical restraint, prevention

Background

Mechanical restraint (MR) is a major infringement on the psychiatric patient's autonomy. Although MR is legal in Denmark, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment concluded, in three reports from 2002, 2008, and 2014 that no medical justification exists for applying instruments of physical restraint to psychiatric patients for days and that doing so amounts to ill treatment (1-3). The Danish parliament changed, during these years, the legislation several times, with no real effect on the numbers of MR episodes.

In 2012, The Ethical Council in Denmark made a statement on the use of coercion in psychiatry (4). The council stated that the use of coercion always constitutes a violation, and large potential for prevention still exists, regarding:

- Focus on prevention
- A culture of equality
- Relatives as a resource
- Coordinated and smooth transfers between departments and sectors
- Adequate capacity
- Upgrading the Mental Health Sector resources
- Respectful dialog between all parties in Mental Health systems
- Research in preventive initiatives.

In 2013, the governmental committee on psychiatry (5), described missing reduction in coercive episodes, as a major challenge. The committee suggested five preventive initiatives for the primary mental health sector:

- Specific focus on competence-development regarding prevention of coercion
- Continuous management focus on reduction
- Ambitious national goals on large and lasting reductions
- Revision of the Mental Health legislation
- Projects targeting MR free units

Additionally in 2013, a project dealing with safety in psychiatry was launched (Sikker psykiatri). The project initiated initiatives to reduce: medication errors, suicide incidents, coercive episodes, and physical diseases. The initiatives to reduce coercive episodes was mainly based on two literature reviews (6;7), the "Six Core Strategy" (8-10), two Danish studies (11;12), and experiences from the earlier "Breakthrough Series". The package of initiatives comprised of:

- Prediction of MR use: in every shift a short safety debriefing is carried out, identifying potential risk factors for MR use.
- Prevention of MR use: At admission the patients experience from earlier admissions is involved in a risk assessment for the use of MR, including individual coping strategies, and personal preferences. Staffs use pre-defined de-escalations techniques.
- Prevention of repeated MR use: Post incident review (staff), patient debriefing, and secondary examination of all MR episodes by an interdisciplinary team from another unit.

Late in 2013, the Budget for 2014 was in place. Here a large majority of political parties in Denmark agreed upon a goal that coercion in mental health should be reduced by 50% before 2020. Specifically the number of mechanical restrained patients should be reduced by 50% because MR is regarded the most intrusive physical coercive measure, but the total amount of all coercive episodes should also be reduced. To support the change

EUR 6.7 million per year was given to the Regions and further EUR 13.4 million in 2014, to improve the physical environment in the psychiatric wards. Also, the Regions should draw up a plan on how to reduce the numbers of MR, and this would be followed by a taskforce, involving representatives from the Ministry of Health, the Health Authorities, and the Regions.

August 2014, the five Regions delivered the plans. The plans included many preventive initiatives that mainly could be placed in the following groups:

- Management focus, top priority and organization
- Development of employer competences
- Participation, involvement and dialogue with patients and relatives
- Physical environment and patient activities

Ultimo 2014, a project regarding MR free units was launched, as part of the Governmental initiative, with participation from all Regions. The framework for the project followed six focus areas (very much inspired by the Six Core Strategy (8-10)):

- Establishing organisational framework and visions, supporting the new initiatives, and continuously, and clear management attention, and support
- Use data-registration-practise as a management tool to facilitate performance, quality improvement, positive learning, cultural development, etc.
- Qualifying staff competences on specific treatment and nursing topics on e.g. recovery, cognitive environmental therapy, trauma informed care, risk assessment, warning signs, de-escalation and conflict
- Use of many different preventive tools, e.g. trauma screening, the use of de-escalation surveys or safety plans, environmental changes to include comfort and sensory rooms, sensory modulation interventions, and other meaningful treatment activities designed to teach people emotional self-management skills.
- Increased patient involvement, clear role formulation, focus on qualified patient supervision towards “noting about us – without us”, and margin for errors
- Systematic use of preventive debriefing to optimise procedures, practice, and treatment plans, and to reduce psychological stress, etc.

September 2015, Safewards was published in Danish (13;14). Some units in the country began already, at the end of 2015, to implement the 10 intervention.

Aim

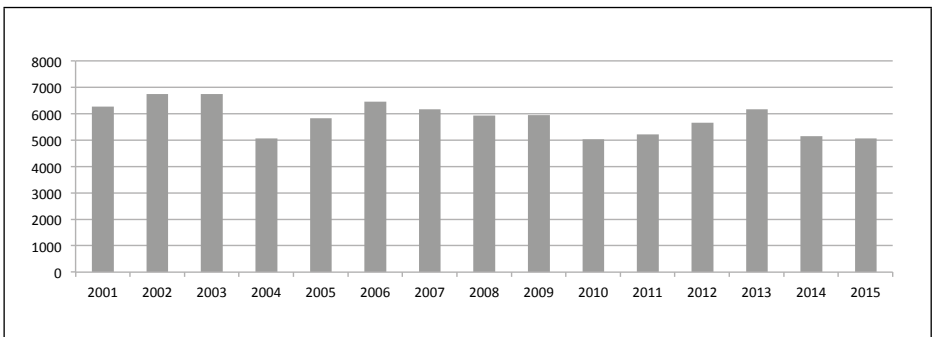
To explore, if politicians have the power, and ability to order a halving of psychiatric patients experiencing mechanical restraint.

Methods

Descriptive longitudinal data will be presented and trends will be analysed using linear regression on physical coercive episodes adjusted for population size.

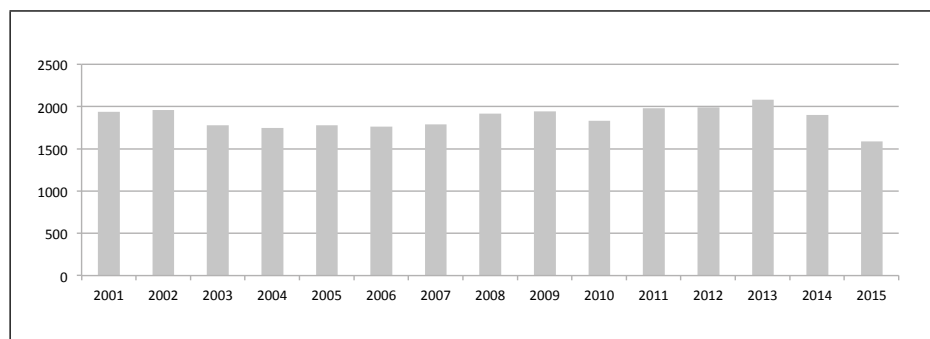
Results

Figure 1. Number of MR Episodes per year (2001-2015)



In 2015 was registered the third lowest number of MR episodes since 2001. Taking the increase in population into account, 2015 represented the lowest number of MR episodes the last 15 years.

Figure 2. Number of MR Persons per year (2001-2015)



In 2015 was registered the lowest number of persons being mechanical restrained since 2001.

Table 1. Trends in the Numbers of MR, Physical Restraint and Tranquilizing Medication (2001-2015)

	B	95% CIs of (B)	p
MR episodes, per year, per 100.000 inhabitants ¹	-1.96	[-3.14, -.77]	.00*
MR persons, per year, per 100.000 inhabitants ¹	-.10	[-.40, .20]	.49
Physical restraint episodes, per year, per 100.000 inhabitants ²	.28	[-1.28, 1.85]	.71
Physical restraint persons, per year, per 100.000 inhabitants ²	-.41	[-.63, -.19]	.00*
Tranquilizing medication episodes, per year, per 100.000 inhabitants ³	5.29	[4.28, 6.30]	.00*
Tranquilizing medication persons, per year, per 100.000 inhabitants ³	.77	[.54, .99]	.00*

Note. The parameters (B) were estimated using a linear regression. 1 MR: A device used on a person to restrict free movement e.g., leather belt, leather cuffs. 2 Physical restraint: Holding a person to restrict movement. 3 Tranquilizing medication: Tranquilizing medication given without consent. * $p < .05$.

Table 1, indicates a significant downtrend in the number of MR episodes ($[B] = -1.96, p < .05$), and physically restrained persons ($[B] = -.41, p < .05$), and an upward significant trend in the number of episodes using tranquilizing medication ($[B] = 5.29, p < .05$) and persons being medicated with tranquilizing medicine ($[B] = .77, p < .05$).

Discussion

It seems like it is possible to reduce MR, even though the downward trend on number of persons experiencing MR was not significant. The most important reason could be the powerful leadership from the top of the administrative hierarchy downwards. The overall figures on coercive measures is static, so it looks like, less intrusive interventions could be used instead of MR. This is probably only a temporarily problem because many preventive interventions often has an effect on several types of coercion, but the main effect of many preventive interventions, need to be inculcated in the culture of the units (cultural change) before major effects are shown. Also new and evident preventive interventions (e.g. Safewards) are being implemented, at the moment, which have not showed their effect in the national figures, yet.

Conclusions

It seems to be possible for politicians to make positive changes to the use of coercive measures in mental health if, they draw on available evidence, leadership, and allocate specified resources.

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Learning objectives

Participants will...

1. achieve knowledge on strategic and organisational developments towards mechanical restraint minimisation in Denmark.
2. be expected to be inspired by the results of afore mentioned developments.

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Unwanted therapeutic events in clinical practice: A role for the Sensory Modulation Strategy

Sub-theme: The minimization/reduction of seclusion, restraint and coercive measures

Workshop

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Keywords: Sensory Modulation Strategy, Seclusion, Restraint, Forced medical treatment, Trauma

Introduction

It is a clinical option in Denmark as in other countries to force a pharmacological treatment and to limit one's freedom when a severe psychiatric disorder results in harm (1). Forced treatment cannot represent a standard when acute clinical situations develop. Preventing and reducing the use of coercion is a high priority in Denmark (2) as well as it is worldwide. 21.9 % of psychiatric patients were treated with coercive measures in Denmark in 2008 (3), but the number of the actual coercive measures was approximately 5 times as high. Economic costs are also high (4). Such scenario poses a major challenge (2), and has been the object of extensive research. Table 1 reports a number of factors that Bak and colleagues recently reported as helpful tools to avoid coercive measures (5). More adaptive and patient centered activities are required and currently implemented worldwide (6). In particular, six factors may significantly change the risk of exposing patients to coercive measures: 1) Staff training; 2) Staff turn over; 3) Acceptable work environment; 4) Separation of acute disturbed patients; 5) Patient-Staff relation and 6) Identification of the crisis' triggers, which are specific for each patient (5). Table 2 reports a selection of the most investigated interventions aimed at reduce the number of seclusion and restraints in psychiatric environment. In the present contribution, the possible role of a technique named Sensory Modulation Intervention (SMI) used to reduce coercive measures and its implementation in the life of an in-patient unit for psychiatric disorders in Denmark is detailed. Aim of the study is to analyze the coercive events in the in-patient unit where the SMI will be implemented. Moreover, the SMI is presented.

Table 1. Strategies that were found to be efficacious as reported by (5) and their possible inclusion in the Sensory Modulation Intervention

Kind of intervention	Significantly efficacious in at least one of the different countries	Efficacious when countries are taken into consideration	Differently efficacious in countries	With a possible implication with the sensory modulator protocol
Cognitive vs non cognitive interventions	Y (favor cognitive)	Y (Norway)	N	N
Staff education	Y (favor educated staff)	Y (Denmark)	N	Y
Alarm system	Y (favor presence)	Y (Norway)	N	N
Separation of acutely disturbed patients	N	N	Y	N
Identification of the patient's triggers	N	N	Y	Y
Patient-staff ratio	N	N	Y	Y
Acceptable work environment	N	N	Y	Y
Substitute staff	N	N	Y	N
Patient-centered care	N (favor patient-centered care)	Y (Norway)	Y	Y

Strategies that were found to be efficacious and are included in the sensory modulation protocol are shadowed.

The Sensory Modulation Intervention

The theoretic background for the SMI is that an environment prepared to deal with the multi-sensory stimuli the patients have to face during their treatments, and a number of sensory-based processing tools can help patients to regulate the stimulation that they are exposed to, which may result in their ability to control the situations of crisis. It is assumed that the use of a specially designed therapeutic space, able to modulate the number and kind of sensory stimuli to the patients, will grant additional opportunities for recognition and reduce the patients level of self-perceived need. It is also expected that providing the medical staff with additional tools to redirect and guide the patients whose condition seems to be escalating, would ultimately help to reduce and / or prevent the need for seclusion or restraint.

Methods

The protocol to reduce coercive measures in a in-patient psychiatric unit is implemented in of the in-patients units at the the Herning's psychiatric hospital, Denmark. The variation of the following events through time is analyzed: 1) use of belts to limit patients' movements; 2) seclusion; 3) unwanted medical treatments; 4) forced hospitalization; 5) forced continuation of hospitalization. Variation through time of these events is observed from January 2010 to March 2016. ANOVA and correlation test will serve for the analyses. Analyses are conducted in R environment (7).

Results

Overall, The mean numbers (year 2010-16) of events are (mean +/- sd): 1)10.83+/-5.64; 2)8.83+/-4.54; 3)3.5+/-1.87; 4)8.17+/-6.11; 5)9.5+/-3.02 for the following investigated events: 1) use of belts to limit patients' movements; 2) seclusion; 3) unwanted medical treatments; 4) forced hospitalisation; 5) forced continuation of hospitalisation.

The total events during the observed period of time were: 66, 53, 21, 50 and 57. The total number of events per year were as follows: 2010 = 3, 4, 3, 4 and 5; 2011 = 6, 9, 3, 6, and 14; 2012 = 12, 7, 7, 17 and 8; 2013 = 19, 10, 2, 7 and 10; 2014 = 12, 17, 2, 14 and 11; 2015 = 13, 6, 4, 1 and 9; 2016 = 1, 0, 0, 1, and 0 respectively for the investigated events.

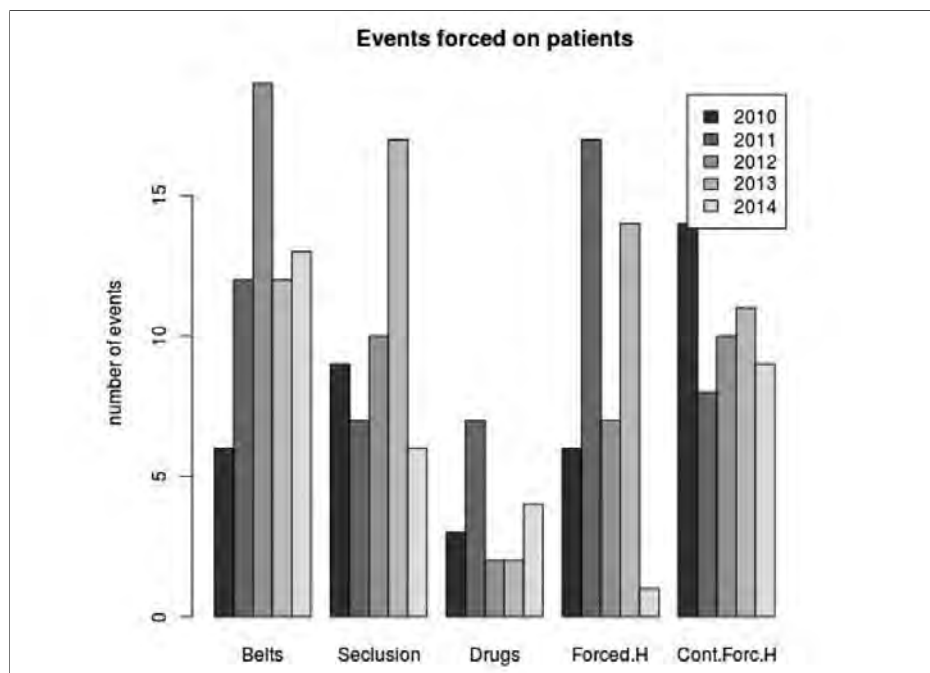
Figure 1 shows the number of forced medical events on patients distributed through time. Fisher exact tests showed a significant correlation between the pairs global number of use of belts and seclusion and forced hospitalization and forced continuation of hospitalization ($p = 0.0025$ and $p = 0.04$).

Nevertheless, this association is to be deemed to be a false positive finding, in that it is not evident when single years are considered separately.

The analysis of the variance and distribution through time of the investigated outcomes showed a significant trend for all the investigated outcomes but the last one.

In particular, F and p values for the investigated outcomes were $F=5.17$; $p=0.0001$; $F=3.67$; $p=0.0029$; $F=2.10$; $p=0.03$; $F=3.57$; $p=0.003$ respectively.

Figure 1: Number of forced medical treatments on patients in the psychiatric in-patient unit



Conclusion and Discussion

The present contribution is a preliminary analysis of the forced medical treatments in a psychiatric in-patient unit in Denmark. This analysis is instrumental to the implementation of a protocol for reducing the number of forced medical treatments on psychiatric patients. The distribution of the following events: 1) use of belts to limit patients' movements; 2) seclusion; 3) unwanted medical treatments; 4) forced hospitalisation; 5) forced continuation of hospitalisation is analyzed in its distribution through time and in the correlation between the different events. It has been that the frequency of forced medical treatments in an average in-patient unit in the western world would be of 5 episodes per month per ward (8).

The EUNOMIA project, a vast survey of the prevalence of coercion in psychiatric units in Europe, reported that physical coercion's prevalence varied from 21% to 59% in different areas of Europe (9). Those numbers prove how a difficult challenge is to reduce the number of forced treatments. As a result of the present analysis, the number of forced medical events varied significantly through time, showing an uncorrelated and complex distribution of the different events. The lack of correlation between the different events and the impact of time through their distribution might suggest that different approaches were implemented through the years, one compensating each other. The sensory modulator protocol holds the potential to work on those aspects of prevention that were found to be particularly efficacious in literature.

Table 2. A selection of studies focussing on strategies to reduce forced treatments in psychiatry (see next page)

Study	Sample	Duration of observation	Family member involvement	Involving cognition approach	Involving combined intervention programs	Patient-centered care and patient involvement	Identification of patients' triggers	Risk assessment	Program elements	Reduction in seclusion / restraint	Reduction in injuries to the patient or to the staff
(10)	In patients, all diagnoses	10 months	No	No	They have combined Anger management and triangle of choices.	Anger management	No	No	Anger management Triangle of Choices	↑ 90% in the use of less restrictive measures	Not stated
(11)	In patients, all diagnoses.	12 months	No	No	The program has combined making an interdisciplinary committee and staff training.	No	No	No	Mandatory Staff Training: Weekly Discussion Items during team meetings; Hospital-wide publicity of the ongoing effort;	↓ 54.6% average duration of seclusion and restraint pr. episode.	↓ 18.9 % staff injury
(12)	In patients, all diagnoses.	42 months	No	No	The program combined staff and patient education with comprehensive programmatic alterations.	Patient education*	No	No	Staff and patient education; Environment Alterations; Communication Feedback Loop.	↓ 94% incidence of restraint and seclusion.	Not stated
(13)	In patients, all diagnoses	24 months	No	No	No	No	No	No	Increased Staff: Patients ratio.	↓ 82% of restraint hours	Not stated
(14)	5-18 year old	20 months	No	No	No	Developmentally appropriate tasks	No	No	Specific staff program; Milieu program.	↓ 26% of using seclusion and restraint.	Not stated
(15)	Adult patients with severe and persistent psychiatric conditions.	5 years	No	No	No	Specific patient involvement*****	No	Yes.	Better staff:patient ratio; Consulting team; Committee membership; Behavior plan standards	↓ 75% using seclusion and restraint	Not stated
(16)	Patients who have a psychiatric emergency.	18 months	No	No	No	No	No	When patients come to the psychiatric emergency center, they will be evaluated if they can be in the waiting room or they have to be observed.	Response team for behavioral emergencies; Staff training, to management aggressive behavior.	↓ 39% of episodes of restraint and seclusion. ↓ 23% compliance	Not stated
(17)	Acute psychiatric inpatients.	2 years	No	No	No	No	Signs of agitation.	Recognition of signs of agitation among patients.	Centered on early recognition of signs of agitation among patients and early clinical intervention; Staff training on assault prevention measures.	↓ 52% in total number of seclusion and restraint	↓ 18.9% staff injury
(18)	Mentally ill individuals over 18 year who need acute treatment	2 years	No	DBT	No	Try to identify the patients' triggers with cognitive approach.	With Dialectic Behavior Therapy.	With Dialectic Behavior Therapy	Survey of Staff and Recipients; New York State Training Curriculum; Focus on interpersonal respect; Policy changing and debriefing; Treatment Interventions	↓ 67% in the combined seclusion and restraint rate.	Not stated
(19)	In patients, all diagnoses	46 months	No	No	No	No	No	No	Implementing the JCAHO 2000 standards	↓ 69% in hours of seclusion and restraint	Not stated
(20)	In patient, all diagnoses	87 months	No	No	No	Filling the coping agreement questionnaire collaborating with nurses.	Yes	Yes	Decreasing initial time in R/S from 4 to 2 hours; Staff education; Use of a coping agreement questionnaire	↓ 32% in number of patients in R/S.	23% in staff injuries.

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Learning objectives

Participants will...

1. learn to differentiate the Sensory Modulation protocol strategies according to a number of different clinical situations, including for example acute manic conditions or acute psychotic conditions versus emotional deregulation during acute phases of personality disorders.
2. have a basic understanding of the practical implementation of the Sensory Modulation strategy based on our experience.
3. identify the key sensory characteristics of patients according to the Sensory Modulation strategy and how to use them in clinical practice in order to decrease the risk of seclusion, restrain or unwanted medical treatments.
4. learn how to describe the problems related to seclusion, restrain and unwanted medical treatment in a statistical way, in order to pinpoint the critical issues, describe trends and suggest targeted solutions. This approach is fundamental in order to write research protocols and to raise funds to implement new clinical strategies.

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Chapter 6 – Education and training

This chapter encompasses presentations on the following sub-theme of the conference:

- Education and training
-

The Missing Element in Your Policy: Liability-conscious Staff-centric Self-Defense Procedures and Training

Sub-theme: Education and training

Workshop

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Keywords: Self-defense training, staff training, employee benefits, human resources management, policy development, liability mitigation

Background and Context

The content and processes contained in this presentation are the result of the author's 35 years in the security and self-defense training field, and the recognition that most WPV policies and training are missing a crucial element. The topics contained herein are, in whole or in-part, included in the consulting and training provided to individual, company and organizational clients as a regular part of his ongoing practice. Additional information and background may be referenced in the following peer-reviewed work in which the author served as an invited contributor.

The purpose of this workshop is to direct participant attention to the need for hands-on staff training in defensive tactics, self-defense, attack avoidance, and escape procedures - the missing elements in most workplace violence plans and policies. Topics will include: 1) The incomplete nature of most plans and policies, 2) The myths & realities about self-defense training and violent behavior, 3) The use of natural human defense triggers and mechanisms as a basis for the techniques and training, 4) A strategic procedural development and training model covering the eight (8) phases of an attack-defense-recovery paradigm and outline of training topics and processes within each phase of the model.

Scope

The scope of the presentation will also include examples of easy-to-learn, liability-conscious, and patient safety-sensitive techniques that are designed specifically for the unique needs of health care facilities, staff, and support personnel during an active attack scenario.

Methods and Results

By combining lecture and instructional teaching methods, participants will come to understand what is needed when adding defense training to a workplace violence plan in a health care facility. Then, using a hands-on approach, participants will be taken through a sample training class that could be used by an actual facility to train its people.

The result will be that participants, whether management, administration, or field care-givers, will realize that:

1. Training for health care providers must be unique and specific to the environment in which services are provided.
2. Such training increases the level of professionalism and capability of the organization, rather than diminishing it.
3. Training and staff proficiency reduces stress in assault situations, thereby reducing the possibility of collateral damage due to panic and staff acting from a position of not knowing.
4. Techniques, tactics, and strategies can be easily learned and practiced with a minimal amount of training with the correct approach and initial premise.
5. Training reduces such organizational problems as: A) High employee turn-over, B) Workers compensation incidents and down-time, C) Liability and financial loss arising from incidents and leading to employee-victim initiated law suits and claims.

Those attending this presentation will learn two important lessons which compliment and add to the overall effectiveness and success of this conference.

Learning objectives

Participants will learn..

1. The importance of taking proactive steps to implement or upgrade their workplace violence awareness and management systems and policies, and...
2. The absolute necessity for training that allows health care workers and support staff to either escape from or directly handle a confrontational situation with techniques that are both liability-conscious and defensive in nature.

Reference

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“It’s all about Communication” versus “Mindfulness” training to minimize patient aggression against healthcare workers: Results from a randomized controlled trial

Sub-theme: Education and training

Paper

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Keywords: Aggression, Training, Communication Skills, Healthcare workers, Mindfulness

Background

Staff training is often recommended as an essential part of any comprehensive approach for preventing and managing workplace violence; yet there is paucity of scientific evidence on the effectiveness of such interventions. Research suggests that there is a direct relation between the communication style and approach that a care-giver uses in their work to the level of aggression experienced by them from patients. In New Zealand, much of the day- to -day care of people with challenging behaviours and those vulnerable are provided by Non- Governmental Organisations (NGOs) in community based residential settings often staffed by untrained healthcare workers. Healthcare workers can be faced with challenging situations in their day- to- day work with minimal training on how to deal with such crises (Swain & Gale, 2014; Gale et al, 2009). It has been established that training in professional courses helps improve patient care and outcomes. Therefore we propose training for healthcare workers will be an appropriate way to reduce their experience of aggression.

Methods

The aim of this study is to trial a group based aggression minimization and prevention programme for healthcare workers working with patients with mental illness, challenging behaviours and other disabilities. The hypotheses that are being tested are: 1. A communication skills training package (“It’s all about Communication”) will result in increased scores in the Interpersonal Communication Competence Scale. 2. A communication skills training package (“It’s all about Communication”) will be superior to mindfulness condition when measured by rates of perceived aggression experienced, reduction in distress levels and increase in general mental wellbeing.

A two arm, cluster randomized, single blinded controlled trial was conducted among unregistered healthcare workers. The intervention package “It’s all about Communication” and control package “Mindfulness” are group based fully scripted and structured educational packages that focus on communication skills and mindfulness techniques respectively. The training consists of four weekly workshops which include teaching, discussion and DVD illustrative examples. All participants were asked to complete a brief demographic form, the POPAS-NZ, Kessler-10, Impact of Events Scale and Interpersonal Communication Competence Scale at baseline, end of the intervention, one month, three months and six months post intervention.

Results

Significant changes in the levels of aggression experienced were reported. The study was conducted between conducted between July 2015 and January 2016. Post 6-months follow up in April 2016, analysis will be conducted and the results will be presented. A quantitative analytical approach will enable the measure of change between the two groups.

Conclusion

When staff are better able to manage and prevent aggression, patients would be dealt with in a more competent and confident manner. When the research has been completed these programmes will be made widely available.

Learning objectives

Participants will...

1. Be able to critique and discuss the importance of workplace and describe its significance as an aggression reduction strategy among healthcare workers.
2. Develop an appreciation of the need for more research in management of aggression and violence to strengthen evidence based practice.

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Making assumptions about healthcare workers' understanding of how to work safely with persons with dementia

Sub-theme: Education and training

Paper

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Keywords: Dementia, healthcare worker, working safely

Background

British Columbia (BC) is Canada's westernmost province, about the size of California, with 4.5 million residents, served by six large publicly funded health authorities, and a many public, private and non-for profit care and social service agencies. Just over 285,000 people work in the health care and social service sector. 90% of the workers are female and 23% are over the age of 55.

WorkSafeBC, the Workers' Compensation Board of British Columbia is the body which both compensates injured workers and sets and enforces the Occupational Health and Safety Regulation ("Regulation") for the province. They also develop injury prevention resources to encourage adoption of safer practices.

The Alzheimer Society of British Columbia's helps families concerned with or facing dementia have the confidence and skills to maintain quality of life. Its main focus is providing resources for the person with dementia and their family members.

For the past eight years WorkSafeBC, has focused prevention time and resources on "working with dementia: safe work practices for caregivers". The reasons - each year over 1,200 claims are accepted for healthcare workers after being injured due to acts of violence and force while caring for persons with dementia. This represents 14% of all claims accepted for the healthcare sector.

Each month The Alzheimer Society of BC offers Family Caregiver workshops throughout the province. The workshop facilitators discovered over 25% of attendees were paid healthcare workers. The question was why were workers attending? The material covered was considered basic information learning: what is dementia; practical coping strategies; and understanding behaviour.

Knowing that the number of persons living with dementia will be increasing based on the demographics of British Columbia. BC has the longest life expectancy in Canada at just over 80 years for males and 84 years for females and over 85% of persons living in care facilities in BC have some level of dementia. WorkSafeBC was noticing the number of workers in healthcare getting injured due to acts of violence while caring for person with dementia was increasing. Based on this knowledge WorkSafeBC approached The Alzheimer Society to discuss a pilot project.

Study aim

The purpose of the pilot project was to determine if there was a need and desire by British Columbia's paid frontline care workers for basic education on the subject of working with persons with Alzheimer's disease and other dementias.

Procedure

The Alzheimer Society of British Columbia and WorkSafeBC decided in June 2012 to work together on a pilot project offering free workshops for paid frontline caregivers working with persons with Alzheimer's disease and other dementias. The pilot was initially planned to be four workshops offered in four geographic regions of the province between October 2012 and April 2013. However, after the overwhelming response to the first four sessions it was agreed that another four workshops would be offered in the fall of 2013.

The pilot project consisted of eight workshops offered in four different geographic regions of British Columbia during the 13 month period, October 2012 – November 2013. Four of the workshops were offered in the largest urban centre in the province (Greater Vancouver with a population of 2.5 million), one in a medium sized urban centre on Vancouver Island (population 360,000), two in the small urban centres in the interior of the province (population 95,000), and one in the largest urban centre in the north of the province (population 70,000). The workshops conducted were offered as all day sessions from 09:00 – 16:00. The workshops were free for participants and included lunch and resource materials.

The morning three hours of the workshop was mostly lecture style with powerpoint slides and a question and answer period. The three hours in the afternoon was more discussion and group work. Participants were asked to bring any questions or concerns they were facing in their current work environment. The facilitator and other participants would then brainstorm ideas to help with these difficult situations workers were dealing with. The added bonus of the group work in the afternoons was the professional connections participants made with each other particularly in the rural setting of North BC. They shared contact information and now had other workers to bounce ideas off of.

A total of 474 front-line healthcare workers attended the workshops and another 523 workers were on the waitlist meaning 997 workers either attended or were waitlisted for the eight sessions.

The Alzheimer Society of British Columbia provided the workshop facilitator and subject matter expert who “tweaked” the session’s materials to focus on worker safety. As well as providing workshop handouts, pamphlets and booklets as in-kind contributions to the project. WorkSafeBC did a brief presentation during the sessions emphasizing worker safety, provided the video content, did the coordination and registration, paid the direct costs and provided resource materials. In total the out-of-pocket costs for WorkSafeBC were approximately \$30,000 Canadian dollars.

Results

The key findings of the pilot project were:

1. The need by British Columbia’s paid healthcare workers for basic education on working safely while working with persons living with dementia was far greater than either WorkSafeBC or the Alzheimer Society had imagined.
2. 98% of the over 450 workers who attended the workshop indicated the “workshop gave me a better understanding of dementia” and 100% indicated “I am now more aware of the importance of my own safety while providing care”.
3. Workers attending the sessions had been working in the field, an average of 11.4years much longer than organizers had anticipated.
4. less than 20% of attendees would be considered new or inexperienced workers having less than 2 years of work experience.
5. A follow-up survey was completed by workshop attendees 3 - 18 months after the sessions were held. The results indicated that workers took the information from the workshop and changed their behaviours by providing a safer environment for themselves, their co-workers and the residents they care for. One Director of Care of a residential care facility who attended the workshop wrote “Breakfast time is always a challenge as care staff are trying to get as many residents up as possible for breakfast as a routine, now with the new knowledge, we don’t routinely wake up residents, we find out what would be the resident’s preference to get up early or would they like to stay in bed for breakfast and get up later, it is now okay for residents to just to come out in their house-gown for breakfast and get dressed later, after-all, it is their home and everyone is safer.”

Conclusion

Based on British Columbia’s experience, it may be important for other jurisdictions to investigate the level of education and training healthcare workers have when caring for persons living with dementia. Assumptions made in British Columbia on the level of understanding and practical working knowledge of workers on this topic were significantly underestimated and further workshops continue to be offered, based on this discovery.

References

WorkSafeBC resources provided at the workshops can be found at <https://www.worksafebc.com/en/health-safety/industries/health-care-social-services/topics/working-with-people-with-dementia>
Alzheimer Society of BC resources provided at the workshops can be found at: <http://www.alzheimer.ca/en/bc>

Learning objectives

Participants will...

1. Comprehend that making assumptions about health care workers understanding of dementia can lead to worker injuries.

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Enhancing students' clinical competence in risky environments through a blended simulation-based learning program

Sub-theme: Education and training

Paper

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Keywords: Aggression, risk awareness, clinical competence, clinical placement, simulation-based education

Background

For Australian students in the healthcare field, it is a compulsory course and professional registration requirement that they engage in clinical placement. This is a type of work-integrated learning, undertaken outside the university, typically within hospitals, community services or other businesses operating within the healthcare sector. It is argued that clinical placement enables consolidation and extension of emerging skills in the context of workplace socialization and plays a pivotal role in student job-readiness training for careers in healthcare (Nash, 2012). This form of clinical exposure also provides students with the opportunity to assimilate the attitudes, values and skills that they require to become appropriately skilled professionals in the environments in which they will practice (Nash, 2012). In the discipline of psychology, students are required to complete a minimum of 1200 hours of supervised clinical practice as a component of their postgraduate training, in order to attain professional registration.

Of note, key stakeholders have raised concerns regarding student clinical placement. There are a number of variables underlying these concerns. Students, universities and industry partners have reported declining access to placements due to increasing student numbers (Department of Health, 2011); limited availability of appropriately qualified placement supervisors to support and educate students (Rudd, Dobozy, & Smith, 2010); limited access to the range of mental health disorders and presentations (Sheen, *et al.*, 2015); and more urgently, potential risks associated with student exposure to unpredictable placement environments (McManamy, Boyd, & Sheen, 2013). It is the latter concern that is the focus of this paper.

Within the literature, two key specific occupational risks have been associated with clinical placement; namely, that healthcare students are exposed to unexpected verbal aggression and also to physical violence from patients. The literature provides data on the frequency and severity of situations that students potentially may encounter and highlights the need for targeted education to teach students how to manage these risks in clinical placements. In this paper, the risks associated with the clinical placement environment are outlined and detail provided on a simulation-based education program, Risk Aware, that was developed to combat these risks, thereby improving the safety and the clinical education experiences of students.

Violence in the healthcare industry

The health care industry is considered to be the most violent workplace in Australia (Perrone, 1999; Victoria, Auditor-General, 2015). Similarly, a survey of NHS Trusts in the UK suggests that healthcare workers are at greater risk (four times higher than normal) from work related violence than the general population (Beech, 2001). While aggression and violence have been identified across the sector, psychiatric wards, that are common placement areas for psychology and other healthcare students, appear particularly prone to violent behaviours. For example, Owen and colleagues (1998) studied five psychiatric settings in Sydney. They recorded a total of 1,289 violent incidents over a seven-month period. Fifty-eight per cent of these incidents were considered serious. The authors concluded that violent incidents across psychiatric settings are a "frequent and serious problem" (p. 1452). Similarly, a Victorian study by Fry and colleagues (2002) recorded 806 incidents of aggression among psychiatric patients in rehabilitation wards. The authors calculated physical assaults occurred at a rate of 97.6 per 100 patients per year. Notably, of these incidents, 55.6 per cent were verbal and 44.4 per cent were physical, with less than one quarter of all incidents reported via formal incident reports. As many aggressive incidents appear to be unreported, the scale of the problem is likely under-estimated.

Similar trends have been noted globally. A New Zealand study led by Swain (2014) for example, investigated aggression towards healthcare workers within a single district. Within a 12 month period, verbal aggression had been experienced by 93 per cent of the healthcare workers sampled, while 38 per cent had experienced a physical assault. A further 65 per cent of respondents indicated that they had experienced a physical assault while at work when the initial 12 month reporting period was broadened. Again psychiatric units, which are common placement areas for psychology and other healthcare students, showed higher levels of destructive behaviour and assaults compared with other hospital wards. Based on international data from healthcare organisations in both the developed and developing world, the World Health Organisation (2002) has concluded that violence in the healthcare workplace crosses borders, cultures, work settings and occupational groups and is now at epidemic proportions in all societies. They go on to state that “violence undermines retention of healthcare personnel and the delivery of quality healthcare everywhere”. Clearly, workplace violence is a significant threat, placing healthcare workers and placement students at risk.

Impacts of violence in the healthcare industry

Workplace violence is often linked to a threat of physical harm. It is important to understand the nature and impacts of violence however, as there are many impacts that extend beyond any physical injuries that may occur. In a study of 2407 nurses registered with the Nursing Board of Tasmania, Farrell and colleagues (2006) found that 63.5 per cent had experienced some form of aggression (verbal or physical) in the four weeks prior to survey completion. They also found that verbal aggression alone was sufficient to cause distress and impact on participants desire to remain in the healthcare profession. Other documented impacts of verbal and physical abuse in the workplace include significant emotional distress and mental illness, decreased productivity and increased potential for clinical errors (Farrell, *et al.*, 2006; Lam, 2002). Furthermore, there may be a direct link between episodes of violence towards healthcare workers and absenteeism, poor recruitment and retention rates and burnout (Denton, Zeytinoglu, & Webb, 2000; Department of Human Services, 2005; Di Martino, 2002).

Given the range of impacts of violence on trained, experienced staff, it is reasonable to predict that students who are inexperienced in managing aggressive incidents, will be particularly impacted. Fisher (2002) studied 260 critical incident reports filed by second year nursing students whilst undertaking clinical placement. The findings demonstrate a wide range of experiences, some positive, but predominantly negative, arising from clinical placement in psychiatric settings. Typical feelings reported by students in association with the reported incidents were fear, shock, anxiety, sadness and anger. Fisher (2002) reported that nursing students undertaking clinical placement in mental health settings face considerable personal and professional conflict arising from the clinical setting. The author further asserted that the duty of care to protect students, borne both by the clinical sector and the student’s academic institution, cannot be ignored. The research clearly highlights there is a critical need for educative action to ensure the safety of all those in the healthcare workplace, including: patients, staff and placement students.

Risk and clinical placement

Unfortunately, there is a dearth of literature pertaining to the direct risks suffered by students undertaking discipline specific clinical psychology placements. The research reviewed thus far does however, indicate a clear and present danger within the placement settings in which psychology students find themselves. The impacts of violent incidents on staff, students and potentially patients, have also been identified.

Studies using paramedic and nursing students suggest that students are often directly exposed to occupational risks whilst undertaking clinical placement (Fisher, 2002; McManamey *et al.*, 2013; Sheen, *et al.*, 2012). As an illustration, a mixed methods study of nursing and paramedic students’ experiences during clinical placements was undertaken by McManamey and colleagues (2013). The results suggested that students were directly exposed to a range of aggressive incidents during their university mandated clinical placements. Across the sample, 10.7 per cent reported experiencing verbal abuse (such as swearing, yelling and death threats), 4.1 per cent reported physical assaults (such as hitting) and 4.9% per cent reported exposure to sexualized behavior (including sexual commentary and physical approaches). Perpetrators included patients, bystanders and in some rare instances, other staff members. Furthermore, across the sample, 11.5 per cent reported experiencing significant emotional distress directly related to their clinical placement experiences. One participant reported: “*A lot of it (clinical placement) is emotionally taxing. It builds up during the day or the week...I sort of got little bits from each job; by the end of the day you are stuffed.*” Similar experiences are highlighted in other student placement studies within the healthcare sector (Fisher, 2002; Sheen, *et al.*, 2012).

Of most notable and particular concern is the trend towards non-reporting of incidents amongst students. McManamny and colleagues noted that of the 43 incidents reported in their study, only one incident (a needle stick injury) was reported by the student to the placement agency or university. This is despite a number of students indicating that exposure to the incident(s) impacted on their emotional and psychological health. This data highlights substantial gaps in students education about taking action and being proactive in protecting themselves against ongoing violence in workplace settings. Universities must lead the way to prepare students to be more “risk aware” in workplace settings and to be “self aware” so they can minimize the impact of incidents when they occur. These activities should be prioritized, built into students core curriculum and assessment, or risk being viewed as an ‘optional extra’.

Clearly, students must be better prepared for workplace education in risky environments and universities have a responsibility to educate students about aggression management in clinical placement settings. Despite their heightened risk, psychology students are not routinely taught strategies to prevent and manage aggression and violence in their pre-registration education (Stubbs & Dickens, 2008), leaving them exposed to adverse events.

Risk Aware

Risk Aware is a simulation-based education program that aids students to identify and manage placement related risk, including the risks outlined above. The design is based on Kolb’s model of experiential learning (1984, as cited in Nash, 2012) and provides a blend of academic and practical learning experiences to improve students clinical competence in the risky healthcare environment. While other aggression and risk management programs exist in Australia, *Risk Aware* has been developed specifically for students and is therefore appropriate to their experience level and training role. The program currently focuses on providing education for psychology trainees, but could easily be adapted for dissemination across other student groups in the healthcare sector.

Method

The content of the *Risk Aware* program was determined via 1) literature review, 2) survey of student experiences across several professional postgraduate psychology programs at an Australian University, and 3) stakeholder consultation and review.

1. Literature review

Studies were included that investigated an element of risk to healthcare students while they were on clinical placements. The following databases were searched: ScienceDirect, Proquest, CCHIntelliConnect, Scopus, Web of Science, Academic Search Complete, CINAHL Complete, Global Health, Health Business Elite, Health Policy Reference Center, Medline Complete, PscyARTICLES, PsychBOOKS, PsychEXTRA, Psychology and Behavioral Sciences Collection, PsycINFO & Social Work Abstracts. Search terms included “health care” AND “student*” AND (“clinical placement*” OR “clinical practical*”) AND (risk* OR “occupational health and safety” OR “occupational risk*” OR “adverse health event*”). All search terms were narrowed to within ABSTRACT except for databases that wouldn’t allow this. This search strategy yielded 37 articles. Reference lists within the articles were reviewed along with grey literature, yielding a total of 84 publications.

2. Student survey

Students across five professional postgraduate psychology programs were invited to complete a survey outlining their exposure to risk while undertaking clinical placement. Specific risks identified within the survey included physical abuse, sexualized behaviour, verbal abuse, psychological distress, environmental hazards and injury or illness. Students were asked to identify any other risks encountered while on clinical placement if relevant and in the event of risk exposure, whether a formal report was filed with their placement agency or university. To date, 43 students have completed this survey (of a potential pool of 64 students). Raw data has been reviewed with further participant recruitment planned prior to publication. Ethics approval was sought and granted to undertake this survey.

3. Stakeholder feedback

Stakeholder feedback was sought from students, staff across eight universities Australia wide and industry based supervisors and managers.

Results

A number of themes were derived from the literature review and survey data. Identified themes were split into modules based on their shared relevance and perceived threat associated with the risk. Seven modules were proposed and reviewed by stakeholders, with some modification to content made. The resulting modules that were targeted for development are identified in Table 1.

Table 1.

Module	Content
Student self-management	Professional dress and presentation; managing professional boundaries; managing multiple demands
Identifying and managing aggression	Cycle of aggression; de-escalation; literature pertaining to restraint, sedation and seclusion
Managing interpersonal risks	Verbal abuse; sexual harassment; bullying; stalking
Managing environmental risks	Environmental awareness; home visits
Infection control	Managing exposure to potentially hazardous objects/fluids/products
Managing psychological and emotional distress	Stress management; burnout; vicarious trauma; debriefing
Identifying and managing education risks	Supervisor/student relationships; feedback; orientation to policies and procedures; reporting

Pilot data suggests that completion of our online Risk Aware program enhances student knowledge, confidence and skills including the communication skills that contribute to productive and harmonious relationships with patients and others in health care settings; critical thinking and problem solving skills that increase awareness and capacity to apply a range of strategies aimed to protect students in particular in risky clinical environments and home settings. We are optimistic that the role-out of our program will promote risk awareness and risk management skills in psychology students that will contribute to a safe and rewarding placement experience.

Conclusion

The Risk Aware program was designed to support students undertaking clinical placement in the risky healthcare setting. This setting has been associated with a significant risk of violence that may impact on the health, welfare and educational outcomes of students. By providing authentic and engaging education experiences that improve students clinical competence in an environment of risk, it is hoped that we can better protect students while also meeting their education needs.

Acknowledgements

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Learning objectives

Participants will be able to...

1. Discuss the placement context and associated risks faced by Australian healthcare students.
2. Provide an overview of the pre-placement program 'Risk Aware'.
3. Discuss the role of simulation-based education in preparing students for clinical placement and minimising risk of violence to students.
4. Explore the applications of this training program nationally and internationally.

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A Solution to Increasing Nursing Retention: Integrating Incivility Education into the Baccalaureate Degree Nursing Curriculum

Sub-theme: Education and training

Paper

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Keywords: Workplace Incivility, Lateral Violence, Nursing

Introduction

Nursing incivility is a widespread threat that occurs in every aspect of the nursing profession from academia to practice. Discussed in the nursing literature over past decades as horizontal violence, lateral violence, workplace violence, disruptive behavior and bullying. A large and growing body of research illustrates the existence of such behaviors and demonstrates their relevance to the nursing profession (Roberts, 2014). The definitions of each portray the same behaviors that are usually non-physical in nature such as sabotage, verbal abuse, de-valuing, backbiting and criticism (D'Ambra & Andrews, 2014; Khadjehurian, 2012; Roberts, 2014). Condon (2012) further indicates that incivility is used synonymously with bullying, harassment, and abuse. The term describes the behavior that is directed from one nurse to another through words, attitudes, and actions.

Problem of Retention

Incivility in nursing has cascading effects that are costly to the health care system and influence patient care. One of these effects is the increased rate of nurse turnover estimated to cost between \$22,000 to \$64,000 per nurse (Oyeleye, Hanson, O'Connor, & Dunn, 2013). In 2010, the American Nurses Association reported that 53% of nurses were considering leaving their current position due to incivility in the workplace. Healthcare organizations are quickly losing their ability to retain qualified nurses' especially new graduates, due to incivility in the workplace (Porterfield, 2010; Small, Porterfield, & Gordon, 2014). These nurses are particularly vulnerable to bullying due to their lack of knowledge, experience, status and power (Thomas, 2010). Nursing turnover rates were estimated at 30% in the first year of practice and as high as 57% in the second year (Twibell, *et al.*, 2012). New graduates are extremely vulnerable to the uncivil environment, with a turnover rate of 30-60% (D'Ambra & Andrews, 2014). Babenko-Mould, & Laschinger (2014), conducted a cross-sectional design study of 126 senior nursing students utilizing the Cortina Incivility Scale (Cortina, Magley, Williams, & Langhout, 2001) to measure incivility in the hospital clinical setting. They found that 59% of the students in the survey reported experiencing staff nurse workplace incivility. In a related non-experimental design study of 117 new graduate nurses, 90.4% of the participants experienced workplace incivility by a co-worker (Smith, Andrusyszyn, & Laschinger, 2010).

With the anticipated retirement of Baby Boomer nurses, there is a projected nursing shortage of 260,000 nurses by 2025 (Twibell *et al.*, 2012). Furthermore, it is estimated that a third of novice nurses who experience nursing incivility intend to leave their current position (Berry, Gillespie, Gates, Shaeffer, (2012); Walfaren, Brewer, & Mulverson, (2012); Laschinger, Grau, Finegan, & Wilk, (2010). With the anticipated retirement of Baby Boomer nurses, there is a projected nursing shortage of 260,000 nurses by 2025 (Twibell *et al.*, 2012).

Need for Implementing Incivility Education

Jenkins, Kerber, & Woith (2013) discuss incivility among nursing students and the need for nursing schools to develop education to correct and prevent these behaviors before they become our next generation of nurses. In their exploratory study (Jenkins, Kerber, & Woith, 2013) tested an incivility education intervention for pre-licensure nursing students. The results illustrated the intervention led to positive behavior changes related to civility among nursing students. In a literature review of the past thirty years, Roberts (2014) found that most of the literature discussed incivility as a learned behavior. Other authors suggest the need for implementing ethical behaviors and incivility education for pre-licensure nursing students (Burger, Kramlich, Malitas, Page-Cuttrara, & Whitfield-Harris, 2014; Coursey, Dickman, Rodriguez, & Austin, 2013). Ihedru-Anderson 2014; Schaefer 2014; and Coursey *et al.*, 2013) further suggest that incivility education in the nursing program will

allow students to think about their practice, evaluate what they are learning, and empower them when they encounter incivility as registered nurses.

In the last decade, there has been a forward attempt in decreasing the incidence of nursing incivility through a variety of interventions, education, and policies. Current literature supports the need for incivility education to provide novice nurses with the tools to effectively deal with incivility in the workplace (Burger, Kramlich, Malitas, Page-Cuttrara, & Whitfield-Harris, 2014; Ihedru-Anderson, 2014; Schaefer, 2014; Coursey, Dickman, Rodriguez, & Austin, 2013; Coursey *et al.* 2013). The author is disseminating this best evidence and translating it into practice. In the last decade, there has been a forward attempt in decreasing the incidence of nursing incivility through a variety of interventions, education, and policies. The literature well documents the need for development of incivility education in the nursing curriculum.

Curricular Model

A curricular model was developed utilizing nursing education to implement incivility components into the baccalaureate under-graduate nursing curriculum. Since students represent the future of the nursing profession and anchor the healthcare system, they need to be given the tools to deal effectively with the problem of incivility (D'Ambra, & Andrews, 2014; Laschinger, Grau, Finegan, & Wilk, 2010).

Competencies identified in the literature for nursing students to successfully deal with incivility are incivility education, communication skills, cultural sensitivity, self-assertiveness training, and professional values and ethics (Burger, Kramlich, Malitas, Page-Cuttrara, & Whitfield-Harris, 2014; Coursey, Rodriguez, Dieckmann, & Austin, 2013; D'Ambra, & Andrews, 2014; Iheduru-Anderson, 2014; Jenkins, Kerber, & Woith, 2013; Khadjehurian, 2012; Schaefer, 2014; Thomas, 2010; & Ustun, 2006). Learning outcomes and teaching strategies were developed to meet successfully the competencies for every level of the undergraduate baccalaureate program.

Specific content in the curriculum follows the sequence of these learning outcomes that build upon the student's progression through the nursing program. As nursing students begin to develop further their cognitive thinking skills, additional content can be added to the curriculum. Teaching strategies developed specific to incivility competencies include analysis and observation, portfolios, role-modeling, cognitive rehearsal training, role-playing with videotaping, lecture, discussion, assigned projects, learning contracts and directed learning modules. Essential incivility content is placed in theory classes, skills labs, simulation, on-line teaching, or in the clinical setting.

Nursing faculty 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 incivility education. Billings and Halstead (2012) 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 interacting with children along with the essential skills. Essential incivility content placed in theory classes, skills labs, simulations, on-line teaching, or in the clinical setting, provides the perfect avenue for incivility education.

Teaching strategies specific to nursing incivility competencies include analysis and observation, portfolios, role-modeling, cognitive rehearsal training, simulation, lecture, and discussion, assigned projects and learning contracts, and directed learning modules. Table 2 illustrates the relationship of the above sample Learning objectives in Table 1 by semester with the proposed teaching strategies.

Table 1. Sample Student Learning Outcomes

1.	The nursing student will demonstrate that he or she has knowledge on the concept of nursing incivility including magnitude, definition, effects, and resources.
2.	The nursing student will demonstrate communication skills such as actively listening to others and considering the impact of his or her action before replying to a coworker, patient, or healthcare team member.
3.	The student will demonstrate the difference between self-assertiveness and aggressive behavior towards patients, family members, or coworkers.
4.	The nursing student will demonstrate a professional manner of acting that ensures the advocacy of the rights of patients, family members, and coworkers to be knowledgeable in making decisions about their needs.
5.	The nursing student will demonstrate the nursing practice and by respect for the individual values, rights, culture and diversity of co-workers and patients.

Based on the past work of Ustun (2006), a problem-based learning curriculum will be created with the goal of providing students with the skills necessary for improved communication. These skills include; self-communication, communicating with multidisciplinary teams, and communication with patients and family members. Students work on 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 (Ustun, 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 videotaping interactions.

Table 2. Teaching Strategies for Sample Learning objectives

Objective	Proposed Teaching Strategy Options	Semester	Evaluation
1	Lecture and discussion, portfolios, learning contracts, role-playing/clinical interviewing with video-taping, simulation, case studies with problem-solving, group/team exercises, self-reflection exercises	1	Portfolio examination Observation and analysis Written examination Reflective journals Evaluation of group process and discussion
2	Role-modeling, role-playing/clinical interviewing with video-taping, simulation, analysis and observation, directed learning modules, lecture and discussion, case studies with problem-solving, group/team exercises	1	Portfolio examination Observation and analysis Written examination Core Plans Reflective journals Evaluation of group process and discussion
3	Lecture and discussion, role-modeling, analysis and observation, role-playing/clinical interviewing with video-taping, case studies with problem-solving, simulation, group/team exercises	2	Observation and analysis Portfolio examination Reflective journal Evaluation of group process and discussion
4	Lecture and discussion, analysis, and observation, role-playing/clinical interviewing with video-taping, simulation, case studies with problem-solving, group/team exercises	3	Observation and analysis Portfolio examination Reflective journals Evaluation of group process and discussion
5	Analysis and observation, lecture and discussion, role-modeling, case studies with problem-solving, simulation, group/team exercises, self-reflection exercises	4	Portfolio examination Observation and analysis Written examination Reflective journals Evaluation of group process and discussion

The proposed curriculum model illustrates how incivility education can be threaded through a four-semester nursing program utilizing Ustun's problem-based model, and the proposed Learning objectives with teaching strategies from Table 2. Additional incivility content can be added within the learning modules to the curriculum that reinforces the Learning objectives and competencies of each learning module (see Table 3).

Table 3. Proposed Incivility Curriculum Model

Semester	Objective	Learning Module	Content Focus
1	1,2, 5	Medical-surgical	Basic communication skills Cultural sensitivity Incivility 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 incivility education throughout the curriculum is a necessary step in stopping the cycle of incivility in the healthcare sector. The above mentioned models illustrate how Learning objectives, competencies and curriculum development related to incivility can be designed and threaded throughout a nursing program.

Significance and Implications for Nursing

The significance of this curriculum model is to provide novice nurses with the knowledge and tools necessary to effectively deal with incivility in the healthcare sector. Current literature supports the need for incivility education to provide novice nurses with the tools to effectively deal with incivility in the workplace (Burger, Kramlich, Malitas, Page-Cuttrara, & Whitfield-Harris, 2014; Iheduru-Anderson, 2014; Schaefer, 2014; Coursey, Dickman, Rodriguez, & Austin, 2013; Coursey *et al.* 2013). Furthermore, there is great significance to the nursing profession as there is no clear curriculum model including incivility education despite its importance and this is the author's effort in translating best evidence into practice (Jenkins, Kerber & Worth, 2013; Billings & Halstead, 2012). Educating our nursing students and giving them the tools to effectively deal with workplace incivility will likely lead to improved nursing retention as it is estimated that a third of novice nurses who experience nursing incivility intend to leave their current position (Berry, Gillespie, Gates, Shaeffer, (2012); Walfaren, Brewer, & Mulverson, (2012); Laschinger, Grau, Finegan, & Wilk, (2010). These implications are of a high magnitude as implementing incivility education into the nursing curriculum could potentially increase nursing retention rates and job satisfaction.

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Learning objectives

Participant will...

1. comprehend the magnitude of lateral violence and incivility on nursing retention rates in the United States of America.
2. have the tools necessary to come up with a curriculum plan, student learning outcomes and evaluation methods to implement incivility education into the baccalaureate curriculum.

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Patient centred physical restraint: a case study of two NHS mental health inpatient wards

Sub-theme: Education and training

Poster

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Keywords: mental health, NHS inpatient wards, patient centred, physical restraint training, needs analysis

Background

Concern abounds regarding the negative effects of physical restraint on both patients and staff. Yet there are situations in the care settings when physical intervention is inevitable and may indeed save life (Paterson 2007, Hollins and Stubbs 2011, DH 2014, NICE 2015, Mind and NSUN 2015). When physical restraint is used for the right reason and the duty of care is maintained right through the process, both staff's and patient's experience of it can be positive (Winship 2006, Steckley 2008, Mind and NSUN 2015).

The training team on the prevention and management of violence and aggression (General Services Association model) at Middlesex University lay emphasises on patient care during restraint process. This is evidenced by the inclusion of local mental health service users who have had the experience of being restrained in their training delivery. The team continually look for ways to improve their training. A member recently conducted training needs analysis that explored the use of patient centred physical restraint practices in an all-male psychiatric and intensive care unit (PICU) and in an all-female acute ward in two differently located NHS mental health hospitals. She worked collaboratively with the ward staffs to identify their experiences and perceptions of patient centred physical restraint in order to:

- Determine whether the approach works effectively with their patient groups.
- Identify barriers to its practice.
- Propose changes if necessary to make the approach sustainable in the setting.

Research Question

How effective and sustainable are patient centred physical restraint practices in mental health inpatient wards?

Methodology

The permission for the study was obtained from NHS Research and Development Department. Phenomenological framework and strategy complemented with focus group and semi-structured interviews were used to collect primary data from the staff who carry out the restraint process and from the key staff who instigated, coordinated and monitored the process. The ethical issues were managed reflexively and the limitations of the study were acknowledged. The tape recorded interviews were transcribed after each session. The analysis followed the recommendations of phenomenological authors such as Giorgi (1985) and of Moule and Goodman (2014) on focus group data analysis

Findings

The actions of the staff restraint team during the process such as: non-pain compliant holds, communicating with and trying to de-escalate the patient and debriefing the patient afterwards vindicated their claim to patient centred practices during restraint process. The model worked effectively with both patient groups in the study wards. It enabled the staff to quickly regain their therapeutic relationship with the patient. Shortage of trained staff and the use of emergency response team could hinder the process.

Implications for practice

The study reinforced 'Best Practice' and reassured staffs that adopted the approach. It reiterated the advantages of patient centred practices during physical restraint including: The minimization of injuries, quick retrieval of therapeutic relationship, promotion of recovery.

Learning objectives

Participants will...

1. gain an insight on how to make physical restraint 'patient centred'.
2. realise that conducting a training needs analysis with the ward staff that use physical restraint strategies in order to identify what works in practice and what needs to be improved.
3. have ideas on how to use the outcome of such studies to continuously improve your training.

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Implementation of trainings on gender based violence in the clinical context

Sub-theme: Education and training

Workshop

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Keywords: Gender based violence, Domestic violence, Sexual violence, medical intervention on gender based violence, clinical lead

Background

Gender-based violence (GBV) has been stated to be a global health problem of epidemical size by the WHO (WHO 2013). Intimate partner violence (IPV) and sexual violence inside and outside of partnership contribute most to this burden of violence. Victims can be female or male, but globally women suffer much more often and more severe violence in partnerships. A WHO-study from 2013 (WHO 2013b) provides prevalence data for partner violence worldwide (see table below). WHO says that every third woman worldwide experiences partner violence during her lifetime.

Table 1: Lifetime prevalence of physical and/or sexual intimate partner violence among ever-partnered women by WHO region

WHO region	Prevalence, %	95% CI, %
Low- and middle-income regions:		
Africa	36.6	32.7 to 40.5
Americas	29.8	25.8 to 33.9
Eastern Mediterranean	37.0	30.9 to 43.1
Europe	25.4	20.9 to 30.0
South-East Asia	37.7	32.8 to 42.6
Western Pacific	24.6	20.1 to 29.0
High income	23.2	20.2 to 26.2

These global numbers can also be broken down into a local context: The following numbers are from a 6-month routine enquiry trial at a gynecological/obstetrics department of a middle sized clinic in Germany (GESINE 2014). 38% of mostly pregnant women patients reported to have suffered some kind of partner violence, 30,5% named psychological/emotional violence, 20,6% physical violence and 11,5% sexual violence. Experiencing violence can have an impact on all aspects of women's health – physical, sexual, reproductive, mental and behavioural health. Health consequences can be both immediate and acute, as well as long-lasting and chronic; negative health consequences may persist long after the violence has stopped.

Numerous international studies validated the following outcomes of violence:

- Death – fatal outcomes as immediate result of a woman being killed by the perpetrator, or as a long-term consequence of other adverse health outcomes, (for example, mental health problems resulting from trauma can lead to suicide, alcohol abuse, HIV infection or cardiovascular diseases)
- Reduced life expectancy – the World Bank estimates that rape and domestic violence – account for 5% of the healthy life years of life lost to women age 15 to 44 in developing countries
- Physical Harm – Injuries, functional impairments, permanent disabilities
- Risky Health Behaviours – Alcohol and drug use, smoking, sexual risk-taking, self-injuring behaviour
- (Psycho)-Somatic Consequences – Chronic pain syndrome, irritable bowel syndrome, - gastrointestinal disorders, urinary tract infections, respiratory disorders
- Reproductive Health Consequences – Pelvic inflammatory disease, sexually transmitted diseases, unwanted pregnancy, pregnancy complications, miscarriage/low birth weight

- Psychological Consequences – Post Traumatic Stress Disorder, depression, fears, sleeping disorders, eating disorders, suicidal thoughts, and low self-esteem (UNPFA-Wave 2014).

Considering the key role of the health sector in dealing with these problems the WHO has provided clinical and policy guidelines *Responding to intimate partner violence and sexual violence against women* (WHO 2013). These guidelines need to be taken on board by relevant medical bodies and institutions internationally. In Germany e.g., the “deutsche Ärztetag 2015”, the so-called German doctor’s parliament requested the German medical chambers to enforce the WHO guidelines and adapt their training programmes correspondingly.

Medical intervention on gender-based violence: Aims

Any medical intervention on gender-based violence aims at preventing violence and thereby preventing a tremendous health burden caused by the experience of violence. Aspiring to reach this main aim needs to successfully pursue the following objectives:

- timely detection of victimization in patients
- sensitive, trauma informed care
- efficient referral to a specialized support institution.

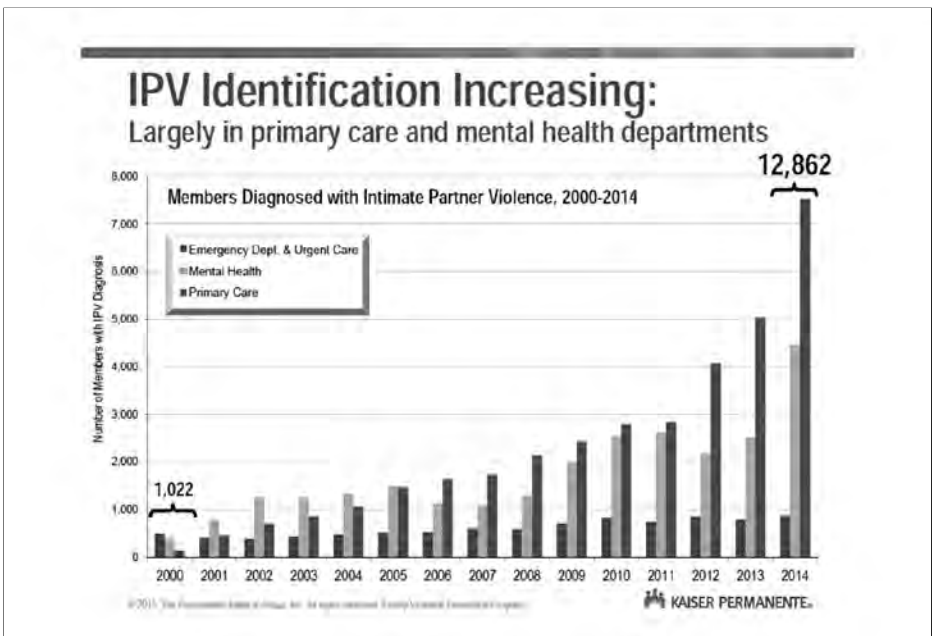
Medical intervention on gender-based violence: The process of implementation

The process of implementing a medical intervention programme requires the following components:

- Training of medical staff (doctors, nurses, midwives)
- providing of information materials (brochures, posters) and tools
- establishing an efficient cooperation with specialized support institution(s)
- monitoring the effect: detection rates, referral rates.

The table below shows the impressive possibilities of taking the issue on board resolutely (McCaw 2015).

Table 2: Identification of intimate partner violence in Kayser Permanente Clinics 2000-2014



GEWINN Gesundheit (GG)– implementing a community based medical intervention programme on gender-based violence

Very few clinics (as well as resident physicians) in Europe yet have a routine in addressing violence and referring patients to specialized support institutions. Forensic documentation in cases of partner or sexual violence is also mostly found to be inadequately established.

Kompetenzzentrum Frauen und Gesundheit NRW (Centre of Competence on Women and Health, North-Rhine-Westfalia = NRW, Germany) has been implementing a program on medical intervention against domestic and sexual violence for several years now. On first stage 5 cities/counties in NRW got funding to install a team of GG-coordinators and GG-trainers and to run the implementation program for the region. All coordinators had to be experienced professionals working in the field of gender-based violence intervention. Special trainings for coordinating and training teams prepared participants for challenges and strategies of this community based approach. In the first year mainly doctors in private practices and psychotherapists were targeted and in a second stage all regions started to work with clinics. Addressing clinics presents a couple of challenges like strict administrative requirements, complicated schedules and immense workloads. Different approaches have been used depending on the starting position of the respective clinic.

The following core factors of an effective implementation of the GG intervention program within the clinics could be identified:

- Backing by management (both medical and administrative)
- installing a cooperation agreement between clinic, coordinating body and IPV support service
- finding a clinical lead (e.g. the head physician of an department)
- flexible schedules of training and follow up plus time to reflect on (changed ?) practice
- a multiprofessionell team of trainers
- adjusting the training according to requirements and „work realities“ of the unit
- involving the local IPV intervention service
- a committed training participation

Eventually there should be agreements about the modalities of the training, the provision of a supporting environment (installing posters, providing brochures, using online information tools etc.) and the installation of an efficient referral path. The basic GG-training program is a 6-hour-modular format in which clinics can set their own focus. Core contents of the training are the understanding of gender-based violence - occurrence, dynamics, health consequences end risk factors, the intervention process of recognizing and addressing the violence issue, informing the patient about support options and efficient referral. Forensic documentation of partner and sexual violence is an extra-two-hour-module provided by a specialized forensic physician.

A workplace policy on gender-based violence is also needed.

Although the training focuses on patients it always needs to be addressed that staff is experiencing violence, too, either in their private and/or in the professional life – both as victims and perpetrators. Clinics should therefore establish a work place policy to reduce harm to the staff and provide adequate support for colleagues experiencing violence – no matter if they are victimized through their intimate partners, through other staff members or patients. The GG standards on workplace safety and support for women provide a framework for clinics to establish their own policy.

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Leaning objectives

Participants will...

1. learn about the challenges to implement a training on gender based violence in the clinical context.
2. learn about different successful formats of training.

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De-escalation and conflict resolution in the acute ward: Simulation-based training in Denmark

Sub-theme: Education and training

Poster

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Keywords: De-escalation, Simulation-based training, conflict resolution, Emergency Department, Aggression management

Background

As part of a new acute strategy in the Danish Health Care System, psychiatric patients will no longer be admitted into hospital via separate psychiatric units but via a central 'joint acute admittance Unit'. Here both patients with acute somatic and psychiatric symptoms are triaged and treated for their acute symptoms. However, this group of patients poses a specific challenge to the staff, usually working with somatic patients. Many staff members express concern about the handling and treatment of patients with various psychiatric symptoms and particularly worry about psychotic, paranoid, manic, suicidal, self-harming and anti-social patients with high levels of anger, fear, impulsivity or aggression.

Central questions are:

- How is the climate of the typical acute environment affected by vulnerable, aggressive patients - not only during treatment but in the waiting areas etc?
- How do we train staff to manage aggressive or psychotic patients when their normal focus is somatic symptoms?
- How can we train staff to understand some of the often bizarre, paranoid and aggressive symptoms often reinforced by acute stress - and talk down the situation thus avoiding lingering frustration?

Method

A two day simulation-based training course involving all types of staff members from an acute ward. The course includes the following elements:

- an introduction to the patient with psychiatric symptoms with special emphasis on the psychotic, aggressive and suicidal patients. Means of violence risk assessment and suicide risk assessment are introduced,
- communicative de-escalating strategies: the six core strategies,
- understanding the triggers of aggressive behaviour and how to control ones' own emotional and physical responses to external aggression,
- basic understanding of and training in security related issues, e.g. where to place yourself in a small room with a threatening patient, how to break free non-aggressively from patients grabbing you,
- simulation-based training with professional actors who role-play the following: The suicidal patient, the high-risk aggressive patient, the manic patient, and the paranoid patient.

Learning objectives

Participants will...

1. appreciate the value of dealing with aggressive challenging behaviour by taking specific mental health disorders (suicidal, high-risk aggressive, manic, paranoid patients) into consideration.
2. learn about the impact "real-life" simulation has on persons undergoing training in aggression management.

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Multilevel meta-analysis of the effects of training programs for direct care staff working with clients with intellectual disabilities and aggressive behaviour

Sub-theme: Education and training

Paper

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Keywords: Meta-analysis, staff training, aggression, clients with intellectual disabilities

Introduction

Direct care staff who work with clients with ID and severe aggressive behaviour problems have an important, but also difficult job. To prevent harm to themselves, to other clients or to colleagues, and to create a safe environment, staff workers may perceive they have no alternative than to use restrictive interventions. Unfortunately, this type of intervention can be counterproductive in the long term, especially when no efforts are made to provide a functional analysis of the clients' behaviour and to provide treatment for the aggressive behaviour (Hastings & Remington, 1994). Besides this, the use of restrictive practices can cause clients with ID to feel *unsafe, frustrated, angry, stressed and anxious*, and can also cause negative experiences of staff (Fish & Culshaw, 2005; Hawkins, Allen & Jenkins, 2005). To strengthen the quality of positive contacts between staff and clients with ID and to reduce the rate of aggression, it is important to use effective, less intrusive behavioural interventions. The positive behavioural interventions that identify the function of the expressed aggression by clients with ID and subsequently teach clients functionally equivalent adaptive skills are considered the most effective interventions (Didden, Korzillius, van Oorsouw & Sturmey, 2006; Heyvaert, Maes, van den Noortgate, Kuppens & Onghena, 2012). However, these behavioural interventions require a range of complex skills of the direct care staff. The need for training programs to educate direct care staff workers is therefore important, especially for staff working with clients with ID and aggressive behaviour problems. According to recent reviews of Cox, Dube and Temple (2015) and Stoesz, Shooshtari, Montgomery, Martin, Heinrichs & Douglas (2016) there are several training programs for direct care staff. However these training programmes for direct care staff have shown a wide variety of goals. For instance, there are training programs who focused on providing more knowledge (McKenzie, Paxton, Patrick, Matheson and Murray, 2000), training programs with a focus on developing more skills (Zijlmans, Embregts, Gerits, Bosman & Derksen, 2011) and there are training programs who aimed to change the attitude of direct care staff towards aggressive behaviour of their clients (Campbell and Hogg, 2008). There are also studies who focused on a change in the aggressive behaviour of the clients with ID (Chou, Harman, Lin, Lee, Chang and Lin, 2011) as a result of a training of direct care staff. The current study is the first study to assess the effects of such training programs for direct care staff and the possible moderating influence of the specific focus of the training program and other intervention, study and participants characteristics.

Aim

In this study we conducted two meta-analyses. The first examined the effects of staff training programs on the behaviour of direct care staff working with clients with ID and aggressive behaviour. The second meta-analysis assessed the effects of staff training on the aggressive behaviour of the clients with ID. With the multilevel meta-analyses the magnitude of effects (training effects) across all eligible intervention studies are studied. We only included studies with a control group design and coded variables such as the focus of the training (on attitude, knowledge or skills for staff and on the frequency and severity of aggressive behaviour or developing new skills for their clients with ID), study characteristics (for instance post-test, follow up, intensity and quality), intervention characteristics (for instance the use of video observation or coaching on the job or the total amount of training hours) and characteristics of the participants (staff or clients) that may account for variation in the training effects in order to be able to test whether they moderate the effect size.

Results

A multilevel meta-analysis of 10 published and unpublished studies with a control group design (containing 76 different effect sizes and N = 9103 direct care staff members) was conducted to examine the relationship

between the focus of staff training and effect size. Overall, we found a significant effect of staff training on the behaviour of staff members. One of the findings is that the focus of a training did not make the difference. In other words, the type of outcome of staff training (for instance knowledge, skills or attitude) did not moderate the effects of staff training. However, the length of the training (training hours) seemed to be important for training effectiveness. That means that more training hours yielded larger effect sizes. When the researchers used observation as part of measuring the effect of a training, the effect size seemed to be higher compared to the use of other outcome measurements such as questionnaires. Finally, a higher percentage of male staff in the research group resulted in a larger effect size.

The second multilevel meta-analysis of 7 published and unpublished studies with a control group design (containing 40 effect sizes and $N = 3597$ clients) was conducted to examine the effects of staff training on the aggressive behaviours of clients. Overall we found a significant effect of staff training on the behaviour of clients with ID. Further, we did not find moderating influences of the focus of the training program or other study characteristics on the effects of staff training on clients' behaviour. However we did find a trend ($p < .10$). Staff training with a focus on learning clients with ID new skills seems to be more effective than staff training with a focus on diminishing the frequency and severity of the aggressive incidents from their clients with ID. A second trend was found for the amount of training hours. Staff training with more training hours yielded larger effects, which replicates the result found in the meta-analysis on the staff outcomes.

Conclusion

Overall, we found a significant effect of staff training on the behaviours of staff members and on the behaviour of clients. There was no moderating influence found of the focus of a training (type of outcome) and effects of staff training on staff and clients' behaviour, meaning that there were no indications that a training aimed to change the attitude of staff towards aggression is more effective than a training aimed at learning direct care staff new skills or more knowledge about the aggressive behaviour of their clients. A higher amount of training hours resulted in larger effect sizes of staff training on the behaviours of staff and clients. Further, study characteristics (the use of observation versus questionnaires) and participants characteristics (percentage male in experimental group) moderated the effects of staff training on the behaviour of clients. Due to the inclusion of a relatively low number of studies (as a result of our sole focus on studies in which the effect of staff training was examined with a control group design), the power of both meta-analyses was not strong. For the future, it is important that more studies with rigorous designs (such as with the use of a control group or Randomised Control Trials) become available in order to replicate our results on the effects of training on the behaviour of direct care staff and on the behaviour of clients with ID.

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Learning objectives

Participants will...

1. gain knowledge on variables that may account for variation in the training effects.
2. receive information for developing training for staff.

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The effect of the Therapeutic Management of Aggression Program on students at a Polish Medical College

Sub-theme: Education and training

Paper

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Keywords: Violence program, aggression, violence

Introduction

The problem of aggression towards the medical personnel becomes an increasing threat in Poland. Violence and aggressive behaviour within psychiatric facilities are serious work environment problems which have negative consequences for both patients and staff. It is therefore of great importance to reduce the number and the severity of these violent incidents in order to improve quality of care. Whereas verbal aggression is a typical phenomenon in the health care, physical violence is also on the increase. The Polish literature enumerates a number of studies describing the scale of the problem which concerns the whole group of medical professions. The research was carried out for one year.

All respondents (N=201) were exposed to patient aggression while doing their job. During the 12 months preceding the study, 96.0% (193) of the surveyed were witnesses to patients' aggressive behaviour towards other workers, and 91.0% (183) fell victim to patient aggression. Witnesses to patients' aggressive behaviour were mostly workers of: general hospitals (98.6%, 72), psychiatric hospitals (98.5%, 67), and primary care practices (90%, 54). During the 12 months prior to the study, one third of the respondents (33.3%, 67) fell victim to patient aggression every day, a similar proportion (31.3%, 63) – once a week, and less than every fifth respondent (18.90%, 38) – several times a month (Kupas *at al*, 2014).

The research demonstrates that the “white personnel” frequently fall victim to violence – 70% of the respondents admit that they experienced some forms of aggression. The personnel of hospital emergency departments, cardiology and orthopaedics departments are the most likely to be faced with patient aggression. However, aggressive behaviour of patients is encountered in all places of work of the respondents. Moreover, 70% of the surveyed group experienced verbal aggression – they were abused or insulted. In more than half of the reported cases, this kind of aggression was used by patients, followed by patients' families (23%) (Lickiewicz, Piątek, 2014).

The literature on the subject describes a number of risk factors of this phenomenon. WHO mentions also broad risk factors, such as specific features of the society (ILO, 2005). These factors are diverse and change in the course of time. They include: male sex, age 25-39 and over 60, mental disorders and psychoactive substances. Other factors are: time of the day, personnel's experience, as well as specific departments (hospital emergency departments, psychiatric and geriatric wards).

The Polish legal system does not support medical personnel in coping with violence. The Mental Health Act mentions only physical coercion means, namely: holding back, forced medication, mechanical restraint and isolation (The Mental Health Act). On the other hand, the Criminal Code provides that whoever verbally abuses a public officer (including a medical staff member) is subject to a penalty (Penal Code, par. 25). In practice of the Polish health care service, the strategy of ignoring is used towards verbal abuse, while coercive means are applied in cases of physical violence.

Although the Polish literature discusses extensively the problem of aggression, it does not suggest ways of prevention. The Polish law does not protect but focuses on punishment of a violent act itself. The global scientific literature more frequently points to the possibility of predicting aggression risk and thus undertaking preventive actions. It is argued that sufficiently early reaction can prevent escalation of aggression.

It is necessary to study the phenomenon of violence in the health care, because it poses a considerable problem which hampers the correct progress of medical treatment. Furthermore, aggression adversely affects the personnel, causing decreased self-esteem, a feeling of anxiety and an increased burnout risk. Even though grassroots initiatives appear at times, there are no systemic solutions. Most actions focus on self-defence training which is supposed to give medical personnel a sense of security. Such training courses are usually taught by qualified instructors of various systems and arts of combat who instruct the personnel how to kick or hit the attacker in case of a direct assault. This is correct behaviour in the light of the Criminal Code's provisions concerning defence of necessity, that is self-defence of people who must repel a bandit's attack. Nevertheless, it stands in contradiction to the regulations of the Mental Health Act which lists as the physical coercion means only: holding back, forced medication, mechanical restraint and isolation. Unfortunately, legal regulations do not specify when a nurse's behaviour towards a patient ought to be interpreted in the light of the Mental Health Act and when on the basis of the Criminal Code. It should also be remembered that the techniques applied are supposed to be effective towards a person who is not an opponent but a patient whose health condition can deteriorate significantly as a result of self-defence techniques used.

The medical studies in Poland do not prepare students to cope with this problem, either. In the medical practice, tranquilizers are often used to calm down a patient, so medical students are taught such a method of action. Classes on specific problems of aggression in the health care are included in the curricula of only two universities in Poland. In the majority of cases it is expected that the rules of coping with patient aggression will be discussed as part of psychology courses. Some schools teach their students self-defence, referred to as civil defence. However, it is in contradiction to the rules of patient care.

The above discussion indicates that actions aimed at dealing with aggression in the health care are focused mainly on the physical aggression aspect and on methods of coping in dangerous situations connected with health- or life-threatening attack. In contrast to this approach, contemporary trends are mostly aimed at prevention of aggression. These methods can be described as "proactive". They focus not on coping with the incident itself but, most importantly, on avoiding it. This is why, they are referred to as "violence management" that is management of a broadly understood violent situation. Currently in Europe there are many such proposals directed at medical personnel. This is due to the specific character of health care personnel's work, connected with the duty to care for the patient's good. Violent incidents cannot always be avoided but attempts should be made to limit their number.

One of such comprehensive systems is TERMA. The name is an abbreviation of the Therapeutic Approach to Violence and Aggression. The system was developed in 1989 in the University Hospital in Bergen. Its authors were the employees of the forensic psychiatry department whose typical feature was long-term hospitalization of patients. The authors of the system noticed that after application of traditional self-defence techniques and introduction of coercive means, the relationship between the personnel and patient worsened significantly, which hampered later medical treatment. Therefore, another, more preventive approach was suggested. It was based on the principle that the program taught should increase a sense of security of both the personnel and patients. On the basis of knowledge of the aggression phenomenon, a program has been developed which enables a therapeutic approach to threat, minimizing the degree of using force and coercive measures in hospital departments. It should be emphasized again that it is not possible to completely eliminate the use of coercive means. However, there is a chance to reduce them and this should be the goal to strive for. A situation of physical violence ought to be regarded as an incident for which we can get prepared but its ultimate result can never be predicted. Too many factors can influence development of the situation and negative consequences can affect both a patient and the medical personnel. Combination of theory and practice is supposed to provide the staff with the algorithm of actions they should undertake in a situation of a violent episode. The primary goal is to reduce the risk of injury both to patients and to the personnel. The key here is prevention, that is such a way of action which makes it possible to avoid physical confrontation and use of coercive means.

TERMA covers both theoretical and practical knowledge which enables to cope better in contact with a "difficult patient". It is directed mainly at the personnel working with patients. As claimed by the authors of the system, it is not possible to learn how to deal with aggression if one neither understands nor has experienced this phenomenon. TERMA course is a standard element of medical personnel training in Bergen. It is taught on the basis of lectures, practical classes and the e-learning platform. It is worth noticing that in Norway every staff member has to undergo TERMA course, irrespective of his or her function in the department. This is due to the fact that in confrontation with an aggressive patient, cooperation of the whole team is necessary, with each member aware of his or her duties and tasks. Subordination to the superiors at work or the social function fulfilled are irrelevant to the effectiveness of action. At the beginning, TERMA

was used mainly in forensic psychiatry departments which especially needed an appropriate procedure of conduct towards an aggressive patient. However, the system proved to be effective also in other departments, including somatic ones. Currently, employees of social welfare institutions and centres for the mentally handicapped are trained in this system, as well. The training course is also completed by teachers and assistants at schools, porters, security guards in hospitals and penitentiary personnel. TERMA has also been included in the obligatory curriculum at several medical universities in Norway.

Methodology

This study was conducted with the aim of ascertaining how violence prevention program can influence perception and attitudes towards aggression in the group of Medical University students. In the present study, TERMA program was used to teach students how to deal with and avoid patient and inmate aggression. The program was covered in 30 hours of lectures, group work, role play and physical techniques training. The program was divided into six modules. The whole course took three weeks in each group of the participants. All groups were led by the same teacher.

The main goal of the research was to determine whether the program would affect perception of patient aggression by the students. Furthermore, the study was supposed to demonstrate a correlation between self-defence classes and a sense of self-efficacy and confidence in one's own capabilities (Breclin, 2008; Weitlauf, Smith, Cervone, 2000).

In the study group, TERMA was conducted as part of their educational program. These were elective classes which students could choose as a part of their regular curriculum of study. Self-reported questionnaires ATAS (Attitudes Towards Aggression Scale) and POAS (Perception of Aggression Scale) were completed in a group setting prior to the start of the lectures and after the course. Moreover, at the beginning and at the end of the course, the students filled in the Hope for Success Questionnaire based on Snyder's concept and the GSES questionnaire (General Self-Efficacy Scale) authored by Schwartz, Jerusalem and Juczyński.

Participants

The study group consisted of 106 students of medical faculties at Jagiellonian University Medical College, aged between 19 and 25 (Mean 21,48, SD 1,61). They were students of medicine (60%), nursing (15%), and physiotherapy (15%).

Findings

The program influenced perception of aggression in the study group. Differences were demonstrated within the scales concerning the attitude towards patient aggression, especially with regard to understanding aggressive behaviour as offensive. The participants started to perceive aggression in a different way. They understand that aggression is not always linked with patient's hostile emotions but also with fear or anxiety. The program was effective especially in the female students group. It also allowed the participants to understand different motivations hidden behind aggressive behaviour.

No statistically significant differences in perception of aggression were demonstrated. It may signify that the classes change the attitudes towards aggression but they do not change its actual perception. Hence, a thesis can be put forward, demanding further research, that the program influences the cognitive element of the attitude and not the emotional one. Moreover, the classes had an impact on a sense of self-efficacy and confidence in own capabilities in the group of the participants. Thus, it indicates that mastering the skills of coping in a situation of conflict with an aggressive patient influences also a general sense of self-efficacy.

The program dealt with the existence of violence inflicted by patients and inmates, and aimed to provide the participants with accurate information about reasons for aggression. It showed students that aggression and violence might have different causes and should not always be perceived as negative behaviour. In general, the study shows that Violence Management Program is an effective tool in changing attitudes towards aggression, which has an influence on future manner of working with a patient.

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Learning objectives

Participants will...

1. understand that the Therapeutic Management of Aggression Program is effective tool for changing perception of aggression and violence.
2. obtain the knowledge about the role of the Therapeutic Management of Aggression Program in the work of health carers.

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Let us all go home safe after work!

Sub-theme: Education and training

Workshop

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Keywords: Safety, Assessment of Environment

Abstract

Safety in work environments remain a concern for employers as well as employees. This world has become increasingly dangerous physically and emotionally which challenges people to return home safely after their work has ended. This presentation will focus on ways to assess environments, behaviors of people, and ways to increase personal safety no matter what situation may arise.

Practical education and principles will be presented to be applied in specific events according to the needs of the participant.

Learning objectives

Participants will...

1. be able to identify assessments to maximize personal safety at work.
2. be able to describe principles for safety that may be utilized in a variety of environments and situations.

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Enhancing Nursing Students' Resilience to Aggressive and Violent Events

Sub-theme: Education and training

Paper

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Keywords: Resilience, Education, Cinemeducation, Humanistic approach, Positive Psychology

Background

Nursing students are at significant risk of aggression and violence in clinical settings within Australia. There has been a plethora of literature observing and reporting the effects of violence and aggression upon registered nurses, but research specifically focusing on these effects upon the nursing student is sparse. Such studies may provide a richer understanding of the impact aggression and violence has upon the lived experiences of the nursing student, workforce retention and workplace satisfaction.

Some general aggression and violence research studies have briefly acknowledged the involvement of nursing students in aggressive situations, but fall short of providing specific advice to aid students in coping with such scenarios (Wells & Bowers, 2002). It has been reported in the United Kingdom that nursing students are assaulted significantly more than any other grade of nurse in the psychiatric setting and as often as other grades of nurses in the general hospital setting (Grenade & Macdonald, 1995). The age of this report highlights that this is not a new problem and may be one that has not been acknowledged and addressed effectively. Some of the abuse reported could be significantly damaging to anyone, let alone an inexperienced student, particularly as some report receiving threats to kill, sexually oriented abuse and racial abuse (Ferns and Meerabeau, 2008). Similar findings have been observed in other international studies with students in Turkey (Celik & Bayraktar, 2004), Germany (Nau, Dassen, Halfens, & Needham, 2007) and Israel (Bronner, Peretz, & Ehrenfeld, 2003) and Australia (Hopkins, Fetherston, & Morrison, 2014).

Consequently, it is important to acknowledge the psychological cost this aggression has upon caring. It may be argued that unprepared students who are exposed to aggression may find their attitudes towards patients are negatively affected and subsequently their role as a carer may be compromised. What is unclear at this time is how to encourage learning about such potentially harmful events in clinical settings with inexperienced students. One way to examine this issue is to explore how individuals react to negative life events and to incorporate teaching and learning strategies that either prevent unhelpful negative reactions or provide protective measures for the students to deal with adverse situations in a constructive way. One such approach that can assist in achieving this is through the use of positive psychology (Seligman, 2000, Fredrickson, 2001, 2009).

Positive psychology in aggression education

The use of positive psychology in education is relatively new but psychologists Fredrickson (2001) and Seligman (2000) have highlighted the effect positivity can have on people's mood and outlook when faced with adversity. Moreover it has been suggested that if channelled correctly, positivity can not only develop an upward emotional spiral, but can also build resilience for future encounters (Fredrickson, 2009). More recently, Seligman's positive psychology research and strategies have been employed in the US army to help soldiers deal with post-traumatic stress disorder by building resilience before and after combat experiences (Seligman, 2012).

Positive psychology shares some core elements with nursing in that it is focused on the well-being of individuals and how to help people to be happier in all facets of their lives including work. The literature from positive psychology offers a very rich research-based tapestry that could be applied to the aggression and violence problem in nursing. It could be used to enhance learning with nursing students and more specifically, to build resilience in nursing students to better prepare and support them to deal with aggression and violence. The application of positive psychology provides an opportunity to develop an innovative pedagogy in keeping with a more person-centred approach to learning.

The role of the cinema in education

As an adjunct to the positive psychology approach we have sought to also promote learning and discussion through the inclusion of movies into the traditional classroom setting. In early attempts, documentary movies were used to promote interest and understanding of international social movements and received very positive feedback from students (DeFronzo, 1982). It has been suggested in the positive psychology literature that many commercial movies are of great benefit to human wellbeing and can be integrated into the pedagogic setting in the form of cinemeducation (Niemiec & Wedding, 2008).

Cinemeducation has been used in aspects of health education for many years and there are reports of its use in medical training since the late 1980s (Alexander, Lenahan, & Pavlov, 2010). Whilst cinemeducation does not replace traditional theory delivery methods, it does suggest that movies can enhance what students learn in the classroom and when used in conjunction with positive psychology, can build character strengths (Niemiec & Wedding, 2008). It has been argued that the use of modern movie clips to foster learning encourages discussion and reflection, both of the movie but also of the self (Blasco, 2006). The use of clips in this manner is said to act as “an alarm” for the student, which will raise awareness for when a similar incident occurs in their everyday life (Blasco, 2006).

This form of education has been successfully used within postgraduate nurse education in the US (Raingruber, 2003) and in the successful delivery of a pain management unit for nurses (Carpenter, 2008). It is clear that for the teaching of emotions and behavioural responses, cinemeducation can have a valued position in healthcare education. The aim of this study was to aid students in the development of coping skills to manage aggression and violence encountered in the workplace through the delivery of a specially designed education program using cinemeducation and informed by a positive psychology approach.

Methods

A quasi-experimental design, using a mixed method repeated measures survey, was used to collect quantitative and qualitative data about personal experiences of aggression and violence from second and third year nursing students, in addition to their responses to two novel education interventions. The ethos of the intervention development was the development of a suitable pedagogy, specifically aimed at undergraduate nursing students and their education of aggression and violence in the clinical setting. Therefore, by adopting a multifaceted approach to the pedagogic design, a new pedagogy for nursing education in the area of violence and aggression has been developed and was implemented as the *Building Resilience to Aggressive and Violent Events* (BRAVE) pedagogy. The acronym BRAVE was used as a means of promoting self-belief and for the individual to be intrinsically brave or courageous in their role when faced with adversity, rather than as an offensive strategy where students could be encouraged to challenge aggressive behaviour.

The BRAVE program tested two approaches. The first approach comprised standard didactic sessions that employ positive psychology and a humanistic approach to promote resilience, while the second incorporated cinemeducation into the standard sessions to further highlight character strengths and virtues required to manage aggressive and violent events. Both education approaches were underpinned by the positive psychology ethos. In the cinemeducation session the movies being used aimed to facilitate discussion and guide the students on a learning journey from the negative hostility of aggression to a positive outcome with emphasis on their own and patients’ well-being and the construction of coping abilities. The current positive psychology informed approach may be contrasted with more traditional modes of teaching and learning about aggression and violence that emphasise safety and management skills.

The sample frame consisted of 97 second year undergraduate nursing students enrolled in a core mental health unit at the commencement of semester one, 2013. This cohort was chosen to test the interventions as they had some experience of the clinical setting as well as some theoretical understanding of patient care and would therefore have some understanding of the context of the sessions.

The program was delivered to four tutorial groups with 23-25 students per group, of which, two groups were allocated to each intervention. The standard education group received the didactic education session and the cinemeducation group received the foundations of the didactic lecture with integrated movie clips throughout. The cinemeducation group also received resilience exercises in the follow up sessions whereas the standard education group received further didactic information relating to resilience and aggression and violence in the clinical environment. This ensured neither group was disadvantaged in the amount of education they received, and both groups were equally well prepared for potential aggressive incidents in the clinical setting.

A cohort of third year students (N=51) were also surveyed at this time to obtain data on their exposure to aggression and violence in the workplace. This data has been reported elsewhere (Hopkins, Fetherston, & Morrison, 2014) and found extensive exposure to aggression and violence in the clinical setting. Consequently it was decided that ethically, this entire cohort of students (N=71) should also receive the intervention. Therefore, the cinemeducation intervention was delivered to this cohort and further qualitative and quantitative data was gathered via a follow up survey.

Within and between group data on resilience to aggression and violence was measured in a group of the second year students (n=20) at three time intervals and at baseline (n=51) and post intervention (n=71) amongst third year students, using the Resilience Scale (Wagnild & Young, 1993). Written qualitative evaluations were collected from both groups of students (n=168) and data analysed using content analysis.

Results

Data was reported at all three time points by the second year nursing students showed a statistically significant positive difference in resilience at different time points ($p < .001$), with a statistically significant mean increase of 6.24 from baseline to post clinical practicum. However, there was no statistically significant difference in students' resilience scores based on education type ($p = .84$). All third year nursing students received the cinemeducation intervention and resilience amongst these students (*Mean Rank* = 69.35) was significantly higher post intervention compared to baseline scores (*Mean Rank* = 53.32, $p = .014$).

Qualitative data identified that the students believed that the cinemeducation enhanced application of knowledge to real life situations in their clinical practice. It was evident from the thematic analysis that students felt they had received a positive educational experience designed to enhance and develop their learning of aggression and violence in healthcare. Students who experienced the cinemeducation session felt that the use of movie clips demonstrated the diversity of aggression and violence and that the movies also provided visual examples of aggression and violence in a safe environment. Some of the student comments were:

"Seeing the different ways aggression and violence is portrayed by the media and realising that because we are so used to seeing it in movies, we may be less likely to recognise it when it happens to us. It seems 'normal'" (Participant 101)

"It was a great visual display of the theory details, which made it easier to link theory and examples with real life. It gave us a better understanding of the content" (Participant 123)

"It was a great way to link theory to practice/real situations. To visually determine differences between behaviours" (Participant 179)

Conclusion

The innovative BRAVE approach used in this study provides an example of how a positive psychology/humanistic approach to aggression and violence education can assist nursing students to enhance personal resilience and develop coping strategies. The cinemeducation strategy also provides an effective and engaging means of integrating the required content into a nursing curriculum whilst demonstrating real world events in a safe and controlled environment. It is evident that cinemeducation and the integration of educational strategies from disciplines other than nursing require further pedagogical consideration and development.

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Learning objectives

Participants will...

1. have an understanding of the personal impact aggression and violence has on nursing students.
2. be able to identify the benefits of cross discipline pedagogies to build resilience in nursing students when faced with aggression and violence.

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Developing together good practices within AVEKKI-model: Cooperation between education and working life

Sub-theme: Education and training

Paper

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Keywords: Cooperation, education, development, prevention of violence, management of aggression/violence, successful practices

Background and Context

Violence in working life is widely discussed in media in Finland (eg. Mansikka 2016, Neuvonen 2016) and its negative effects are clearly recognized (Heponiemi *et al.* 2009). There is real need for developing safety in work as well as prevent and manage violence.

AVEKKI is a Finnish practice and education model to prevent and manage aggression and violence in working life. Abbreviation AVEKKI refers to Finnish words meaning aggression, interaction, prevention and anticipation of violence, education, development and integration. The model was originally developed during EU-funded project 2004-2007 (AVEKKI-koulutus- ja toimintatapamalli väkivaltatilanteiden ennaltaehkäisyyn ja hallintaan -projektin loppuraportti 2007). Within the last 10 years, the model has been intentionally further developed, updated and widely used in health and social care, work with people how have special needs, basic education, early childhood education as well as education for becoming professionals of these branches in Finland.

The AVEKKI-center in Savonia UAS is responsible to educate and qualify AVEKKI-instructors as well as to develop the model. There are around 120 AVEKKI-instructors educating the model in their work areas. Continuing co-operation with the AVEKKI-center, AVEKKI-instructors and working life representatives has strengthened the implementation and functionality of the model and, furthermore, raised up certain well-functioning practices and procedures to promote safety in work.

Implications for practice, education & training, organizations / management, policy and guidance

AVEKKI practice and education model

Basic AVEKKI education takes 12 to 24 hours, based on the individual needs of work place and participants. The comprehensive AVEKKI model consists of:

- recognizing the factors influencing safety and interaction related to aggression
- prevention and anticipation of aggression
- controlling employee's professionalism and alertness
- assessing of threat and violent incidents in work
- choosing course of action and safe controlling
- post-settlement of occurred incidents and needed further actions
- communal assessment of realized action and learning through it. (Aho, Airaksinen, Hakkarainen, Lommi, Taattola 2015.)

Theoretical understanding of aggression and its management is seen vital in AVEKKI. Education includes practical exercises like calming down skills, various physical controlling techniques, certain releasing techniques for grips etc. These rehearsals are always strongly connected with theory, not seen as a separate exercise. Especially aspect of safety and interaction are emphasized. Professional action on certain threatening situations are rehearsed as a full scale simulation.

One important part in AVEKKI is the three level rating system of aggressive situations and as well as coding different alertness levels as well as professional's state of mind (eg. Jeff Cooper s.a). These matters are essential to understand, thus they are constantly referred in the different stages of the AVEKKI model.

Successful implementation of AVEKKI in work life demands tailor-made, appropriate education which carefully concerns participants' level of knowledge and skills in aggression management as well as unique needs for aggression management in their work. Obviously, well-functioning AVEKKI practice model requires communality and co-operation between AVEKKI instructor, individual employee and patient, working team, directors and organization. To develop and maintain one's competences to work according to AVEKKI model and to support model's realization in working life, can be enabled by involving AVEKKI maintenance course as a part of units' continuous education plan. These maintenance or further education courses are once again individualized to respond to the demands of the working unit. (Aho & al. 2015.)

Basic AVEKKI education (12 to 24 hours) is included in the curricula of social and health care and security sector students in over ten different vocational colleges and universities of applied sciences in Finland (eg. Heikkinen, Korhonen, Korhonen, Rutanen, Rönkkö, Aho & Pennanen 2016). The students will gain general understanding and skills related to prevention and management of aggression during their education.

AVEKKI instructor education and promotion of instructors' competences

AVEKKI instructor education (9 ECTS) has been carried out yearly by the AVEKKI center of Savonia UAS. The AVEKKI instructor needs to master education procedure of AVEKKI comprehensively: profound basic knowledge about AVEKKI model, understanding of the participants' basic work in their specific work unit, pedagogy and interaction and cooperation with all key persons. Instructor education increases and deepens competence about AVEKKI model and process, principles of adult learning and teaching and special questions concerning working as AVEKKI instructor.

Various learning and teaching methods are utilized in AVEKKI instructor education also in order to provide instructors with possibilities to use them when educating AVEKKI. One of these methods is simulations including skill stations and full scale simulations, so instructors are introduced to use simulation pedagogy in courses they'll carry out. Consequently, importance of understanding and managing all the learning phases of simulation are emphasized (eg. Dismukes, Gaba & Howard, 2006; Fanning & Gaba, 2007; Rosenberg, Silvennoinen, Mattila & Jokela, 2013.)

In order to support AVEKKI instructors and their professional development, further education days are arranged annually by the AVEKKI center. Subjects and themes for these days are chosen according to the need of instructors. To broaden and deepen understanding of topics related to aggression, its management and to solve challenges in education, external experts have been used as lecturers. Face-to-face reflection of instructors' experiences about teaching AVEKKI is significant. It gains sense of community within instructors and allows them to share and learn from each other. In addition to further education days and informal social media applications, web-based learning platform is in use for AVEKKI-instructors to foster their cooperation, to disseminate the newest/updated knowledge and also to inform all the instructors efficiently when needed.

AVEKKI center certifies each instructor after passed education and re-certificates (awards license to educate AVEKKI) instructor every third year by testing their AVEKKI substance as well as pedagogical competence. Quality assurance of instructor skills is absolutely crucial because of their pivotal role in management of aggression. Anyway, its implementation is not easy because of various aspects, not least because of limited resources (eg. McCormack & McKenna 2014).

Good practices developed in successful cooperation within AVEKKI

AVEKKI three level rating system is used in AVEKKI to define the seriousness of occurred aggressive incidents and to plan and implement appropriate, professional action to safely control these incidents. The rating system can be used by individual worker or family member as well as whole work team. (eg. Kauppila *et al.* 2016.)

Aggression is one of the most frequently reported reasons for psychiatric hospitalization of children. That is why importance of prevention and management of aggression is quite well recognized nowadays. (Crocker, Stargatt & Denton 2010.) In Tampere University Hospital Child Psychiatric Department, the AVEKKI rating system is utilized to find more possibilities to prevent and manage challenging situations in the child's everyday setting more efficiently. The use of rating system can decrease the use of physical interventions

and risk of injuries. Moreover, the rating system works as a tool for the nurses on the wards to support their professionalism.

The AVEKKI rating system includes three color codes: red, yellow and green. In red category the child for example rages, kicks, hits, throws things and tries to hurt him/herself. Yellow category includes situations where aggression is more moderate; the child is verbally aggressive, agitated, restless or anxious. The green one is for low level of aggression and the situations are normal part of everyday living; child objects washing his/her hands, doesn't want to get dressed, doesn't want to obey in everyday situations. (cf. Cacciatore 2008.) When applying the AVEKKI rating system a nurse reflects different types of challenging situations and possible predictive triggers with the child, family and also for example with teachers by using a specially designed document. This document can be refilled or altered as the situations change. The adults who deal with the child learn to react consistently and logically in the child's challenging situations. By using this form together with the child she/he becomes more aware of her/his own behavior, learns self-control and self-regulation. The adults may increase their capacity to use appropriate methods to manage situations safely.

Functional and genuine collaboration inside a certain organization and with their cooperative partners in Finland is recognized. Successful prevention and management of aggression in working settings demands for seamless cooperation between organization and its management, work community, professional/worker and client. To create and foster collaboration between those different actors needs continuing discussion and compromising is needed. The modified AVEKKI model which acknowledges organization's characteristics and is genuinely communally planned promotes to master prevention and management of aggression as well as overall safety culture (Aho & al. 2015.)

There are examples of organizations where AVEKKI model is deeply adopted and further developed. Peculiar to these successful cases is that AVEKKI instructors have worked by persistent and goal-orientated way. Moreover, you should not underestimate personal skills of AVEKKI instructor when she/he cooperates with actors of many levels with their different characteristics, positions and demands.

Continuing development of the AVEKKI model to respond to current needs of working life has been taken into consideration in various ways. The AVEKKI center must maintain its capacity to verify that the model is adequate and updated. Following changes in society, collaboration between AVEKKI instructors and working life enables to respond to this demand. For instance there are procedures to activate instructors' co-operation as well as to establish relations with other professionals involved in matters that promote safety. Furthermore the latest update of the model highlights the importance of effective communication skills to avoid "too physical view" of managing aggression.

Research for developing the AVEKKI model and its implementations has been conducted. There are a few scientific studies carried out at the universities, however, the most of studies have been carried out by social and health care students as theirs thesis and project works at UASes. These studies have provided information for example about participants' experiences and viewpoints related to AVEKKI courses as well as its applicability to enhance safety.

Discussion

During past ten years the AVEKKI model has been developed and modified in multidisciplinary and diverse collaboration between AVEKKI instructor and other actors in the working life. The model is generated to be more structured and simplified to certain extent. However, there is a clear demand for further development because of substantial changes in operational environment (especially in social and health care in Finland) and legislation. There is need for scientific research related to the AVEKKI model's efficiency to safety as well as cost-effectiveness. It would be important to reveal all the factors related to the functionality of the AVEKKI model, because there are differences within organizations related to adoption of the model. Certainly, there is a huge potential within tens of AVEKKI instructors: to harness all this capacity for all AVEKKI instructors could still be improved.

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Learning objectives

Participants will...

1. be aware of AVEKKI practice model to prevent and manage aggression.
2. have an understanding about protocols used to educate and implement the AVEKKI model.
3. Be able to compare good practices of successful cooperation within AVEKKI with his/her previous understanding and experiences.

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Domestic Violence: A Mental Health perspective

Sub-theme: Education and training

Paper

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Keywords: Violence, Women, Mental Health perspective, mental health issues of abuser and victim

Background

Violence against women is widely recognized as an important public health problem. It has immediate and long lasting consequences on mental health of the victim.

Systematic studies revealed that 30-90% of women in domestic violence programs have identifiable mental health problems. (UN special report 1996, NFHS 2005-06).

On the other hand, the risk of violence has been found to be much higher in case of abusers with severe mental disorder and substance abuse. This indicates that domestic violence may also be precipitated by mental health problems among the abusers.

Various psychological and psychiatric conditions have been identified among the victims and abusers as well that are the primary contributory factor to domestic violence in several cases.

Objective

It was considered quite essential to look into the issue of domestic violence as a part of the urban mental health.

Material and methods

In this context, efforts were made to collaborate with various NGOs working in the field of domestic and gender based violence. A semi-structured questionnaire was prepared and administered on domestic violence victims visiting these organizations by interviewing them in detail about various aspects of the trauma experienced by them and the nature of intervention received.

Results and discussion

Exactly 50% of the respondents stated that they were not satisfied with the intervention received. Majority of the victims also acknowledged the perceived need for systematic psychological counseling and intervention for themselves as well as their partners. Majority of the victims felt that the psychological/psychiatric interventions are essentially required for the abuser as well.

Keeping in view, the preliminary data collected from interviews with the victims of domestic violence regarding the impact and pattern of violence being incurred upon them and the perceived adequacy of intervention received from various NGOs or Government agencies, the development of intervention modules was conceptualized and implemented.

Learning objectives

Participants will...

1. appreciate the magnitude of violence against women as an important public health problem and concern with long lasting consequences on mental health of the victim.
2. appreciate the necessity of the gender based approach when handling violence.

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Violence prevention and verbal de-escalation – training and implementation in a psychiatric hospital

Sub-theme: Education and training

Paper

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Keywords: Psychiatric nursing, de-escalation management, violence prevention, training program

Background

The Integrated Psychiatry Winterthur (ipw) is responsible for the primary psychiatric care of a region in the Canton of Zurich, Switzerland with a population of 430,000 and has five acute care wards for adults. The ipw has been using the “Model of Connecting” (Oud 2015) for de-escalation and aggression management for the last ten years, but no formal de-escalation training has been implemented. Studies show that agitation and the potential for violence can be minimized through the use of verbal de-escalation (Richmond *et al.* 2012 and Wesuls *et al.* 2013). It is ipw’s goal to reduce the number of patients in involuntary treatment.

Methodology

In order to meet the goal of reducing the number of forced treatments, the nursing department had several employees trained at the Institute for Professional De-escalation Management (ProDeMa 2016) to be de-escalation coaches. Additionally, the internal aggression management has been reoriented towards verbal de-escalation. Twelve two-day seminars have been planned over the period of one year, in order to train all members of the nursing staff. The program has not been fully evaluated yet.

Findings

The implementation of the new aggression management is still in progress. Those who have attended the seminar, find the reorientation towards verbal de-escalation to be worthwhile and especially useful in a way that allows them to reflect on their own work. As a result seminar participants have recognized that rules and regulations can trigger aggression. Overall, the feedback on the program has been positive.

Implications for practice, education and training

Even though the project has not yet been completed, the following conclusions can be drawn: Self-reflection is valuable for professional development; Participants learn from each other’s experience and expertise; Verbal de-escalation can be implemented immediately; A multi-professional approach is a prerequisite to success.

Discussion

This case study was initiated because of a subjective dissatisfaction with the methods for handling aggression incidents. The relatively high number of patients in involuntary treatment confirmed this. The preliminary findings are based on the first evaluation of the seminars. To determine whether the reorientation of internal aggression management towards verbal de-escalation is working, it will be necessary to compare the numbers of involuntary treatments before and after the trainings of staff and further research is suggested.

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Learning objectives

Participants will...

1. gain an insight in the process of implementing the methods of verbal de-escalation in a mental hospital.
2. have an understanding of the interaction of various factors implemented in the seminar.

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Shifting Focus – Implementing Violence Reduction Training that Highlights the Importance of Communication Skills

Sub-theme: Education and training

Workshop

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Keywords: Training, Communication, Violence reduction, Staff service user interaction, Least restrictive practice, Changing culture

Abstract

Nottinghamshire Healthcare Foundation Trust provides services across the county for people with mental health needs, with needs relating to drug or alcohol dependency, mental and physical health services for people with intellectual disabilities and community physical healthcare. The Trust also provides secure mental health services, including low, medium and high secure services. The trust employs 8,800 staff including mental health nurses, psychiatrists, social workers, healthcare support workers, allied health professionals, psychologists, community nurses and physical healthcare nurses.

Within Nottinghamshire Healthcare, preventative practice is always the first and preferred approach to reducing violence within the workplace. The Trust is committed to providing a safe and therapeutic environment that will allow the delivery of effective and compassionate care to all. Recognising the importance of safe, considered and proportionate physical interventions, the Trust has committed to developing and implementing a single organisational training curriculum for all staff that will reflect the clinical needs of each service.

A Trust-wide initiative began in February 2016, following involvement in the co production of a new High-Secure Violence Reduction Training Manual. The aim of this Trust-wide initiative is to develop a consistent approach to staff violence reduction training across all of the services delivered by Nottinghamshire Healthcare Foundation Trust. Key changes have included a top-down review of current practice, an increased focus on staff – service user interactions, and a renewed commitment that all violence reduction training throughout the Trust will encompass the philosophy of least restrictive practice.

The techniques taught within the Violence Reduction Training programmes have been reviewed, with an increased focus on strategies that do not include physical interventions. Core physical intervention techniques have been identified which are transferrable across the different services within the Trust. This has led to a reduction in the number and variety of physical intervention techniques that are taught.

The development of the Violence Reduction Training programme has also included an innovative and unique collaboration between Rampton Hospital Speech and Language Therapy Team and the Violence Reduction Teams within Nottinghamshire Healthcare NHS Foundation Trust. The aim of this collaboration has been to enrich communication skills and increase staff awareness of the importance of staff-patient interactions by developing a model for embedding communication and de-escalation skills training within all aspects of violence reduction training.

It is anticipated that this new approach to Violence Reduction Training across teams within Nottinghamshire Healthcare Forensic Services will have a significant impact on the culture of the services delivered across the Trust. The focus on least restrictive approaches to preventing and managing incidents of violence and aggression, and the emphasis on responding to service users as individuals, will support staff to develop and maintain safe and therapeutic environments that will allow the delivery of effective and compassionate care to all.

This workshop will share examples of the training tools that have been developed within Nottinghamshire Healthcare Foundation Trust and explore the benefits and challenges of implementing a consistent violence reduction training programme across a wide range of mental health services and staff groups.

Learning objectives

Participants will...

1. gain and awareness of the challenges of implementing a consistent training package across multiple services.
2. gain an understanding of the innovative training tools used within Nottinghamshire NHS Trust
3. gain an understanding of the processes involved with reducing the number of taught physical intervention strategies.

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Genuinely present – professional working in one-to-one nursing situations: A course for nurses

Sub-theme: Education and training

Paper

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Keywords: Effective presence, one-to-one nursing, management of aggression/violence, development, communality, learning methods, course

Background

Close observation / one-to-one nursing is used to manage patients' aggression, self-harming and confusion especially in inpatients care. Terms and practices for these interventions vary but what is often emphasized in these occasions, though, is the effective presence by the nurse. However, courses or education to enhance professionals' knowledge and skills about it is rarely systematically provided for nurses. Furthermore, many policies related to one-to-one nursing call for certain communality and shared understanding within a care team and organization. With support by the European Social Fund Programme, the special course was developed for nurses who conduct one-to-one nursing or so called "effective presence" to promote safety in work and for patients, and in certain incidents, to avoid the use of coercive measures such as seclusion in practice.

Methodology

Multidimensional approach was used in developing the course "Genuinely present –professional working in one-to-one nursing situations": the literature review about the subject was carried out, over ten group and individual interviews of nurses, patients and patients' family members was conducted to reveal experiences, knowledge and aspects about the theme; expertise of experienced nurses was acknowledged continuously; pilot courses including evaluation questionnaires were implemented for the staff nurses. All the data was analyzed and synthesized to form the framework, content and learning methods for the course.

Findings

The course consists of the following themes: forming the connection with the patient; mastering the basic nursing work; nurse's self-knowledge; speciality about interaction in one-to-one nursing; communality in one-to-one nursing; reporting, reflecting and debriefing. Concrete examples of content, used exercises, simulations and other learning methods will be presented.

Implications

The following implications for practice, education & training, organisations / management were seen significant to gain understanding and skills about effective presence:

- Effective presence can be realized as a more structured intervention: it helps nurses to conceive the phenomenon as a whole.
- Concrete case examples, exercises and simulations related to pattern about how to form connection with the patient provide nurses tools to utilize in practice: how to make a patient feel safety, trustfulness, continuity, equality and certain similarity.
- In addition to nurses' personal perspective, to see one-to-one nursing from communal viewpoint: the whole team should participate the course, including team superiors, to facilitate reflection and mutual understanding more efficiently. It is crucial also from ethical viewpoint – patients who are under one-to-one nursing can be in risk for unprofessional use of power and authority.
- Placing oneself into a patient role in the course is eye-opening: exercises gives live, remarkable experiences to utilize in work. For instance principles of calming touch and reactions for successful or unprofessional interaction can surprise even experienced nurses.

Learning objectives

Participants will...

1. have an understanding about content and used learning methods in the course “Genuinely present – professional working in one-to-one nursing situations”.
2. have an increased awareness about personal and communal perspectives related to one-to-one nursing and those contribution to management of aggression.

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Evaluation of a training program to prevent and manage violence in a mental health setting

Sub-theme: Education and training

Paper

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Keywords: Aggression, Psychiatric hospital, Psychological Distress, Confidence in coping, Education and training program, Violence

Abstract

Workplace violence may lead to serious consequences for victims, organizations and society. Most workplace violence prevention programs aim to train staff to better recognize and safely manage at-risk situations. The Omega education and training program was developed in Canada in 1999, and has since been used to teach health- and mental health-care workers the skills needed to effectively intervene in situations of aggression. The present study was designed to assess the effects of Omega on employees' psychological distress, confidence in coping, and exposure to violence. This education and training program was offered to 105 employees in a psychiatric hospital in Montreal, Canada. Eighty-nine of them accepted to participate. Participants were asked to complete the same questionnaire at three points in time: before the training, after a short period (i.e., M=109 days) and at follow-up (i.e., M=441 days). Repeated-measures ANOVAs and Cohen's *d* effect sizes were calculated. Results demonstrated statistically significant improvements in short-term and follow-up posttest scores of psychological distress, confidence in coping, and in levels of exposure to violence. This study is one of the very few to demonstrate the positive impact of a violence prevention training program and it goes further. Further research is needed to understand how to improve the effectiveness of the program, especially among participants resistant to change.

Learning objectives

Participants will...

1. have an understanding of a strategy for reducing patients' aggression in inpatient psychiatry units.
2. will have an understanding of the psychological outcomes of a violence management training.

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Provincial Integrated Violence Prevention Education Completion Rate Reporting Initiative

Sub-theme: Education and training

Paper

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Keywords: Violence Prevention Education, Consistent Reporting, Integrated Data

Abstract

Violence in the workplace has been a high priority for the healthcare sector in British Columbia, Canada, for many years. Recently, a collaborative initiative began, with an aim to create more valid, consistent reporting in BC healthcare. This also included an initiative to reduce the risk and impact of violence by raising the completion rates of violence prevention education among workers most at risk in BC healthcare. This paper illustrates the effort required to integrate education completion rates for all active employees in “High Risk” departments. This represents half of the larger project of integrated reporting of violence in BC healthcare. The other half of the project is focused on provincial reporting of incidents of violence in the workplace, and is presented separately.

This project began with obtaining all the course completions and employee data from 6 BC Health Authorities (HA). This data came from 7 different databases in excel and SQL extracts for both online and classroom courses. Data assimilation was completed using multiple methods as each database and HA used different linkable data fields. Additionally, much of the data needed to be cleaned of errors in manual entry fields. Each HA provided a list of their “High Risk” departments in one of three categories of Mental Health and Addictions, Emergency and Residential Care

After the initial data investigation, it became apparent that due to some data entry practices many records needed to be updated before they could be useful. Such practices include not including identifiable information in online records, and putting all course completion records under the instructors account. This highlighted that the methodology to use in course completion documentation must be agreed to, documented and adhered to.

The next step required fitting the courses into the 9 course topics. This step became more challenging than initially expected as the list of accepted courses grew over the length of the project. In addition, the courses did not fit into the 9 topics in a one to one ratio. Some courses were collections of topics and so one completion counted for multiple topics. Most topics had multiple courses that could be taken for credit. Obtaining the privacy agreement from each HA was a significant challenge and all outputs from this project were also kept at a summary level, such as HA, facility or program.

This project continues in 2016 with some notable improvements. Efforts are underway to collect all the data through SQL connections to reduce the manual efforts, and ensure consistency between data acquisitions. Several of the HAs are also switching between online education providers which will reduce manual entry errors. HAs have learned that data must be recorded in a way that it can be assimilated and guidelines to ensure this should be documented. This initiative for consistent, valid reporting of BC violence prevention education completion rates for “High Risk” departments is paramount to the safety of the healthcare sector.

Learning objectives

Participants will...

1. learn about documentation of Data Entry/Recording Methodology to Ensure Consistent Reporting.
2. learn about continued Analysis of Outcomes/Measures to Ensure Valid/Complete Reporting.

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Why don't student paramedics report acts of workplace violence against them?

Sub-theme: Education and training

Paper

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Keywords: Workplace violence, student, paramedic

Background and context

Previous research has shown paramedic students are exposed to various acts of workplace violence during ambulance clinical placements. The most common form of workplace violence experienced by paramedic students is verbal abuse with sexual harassment the most severe form. Paramedic students who are exposed to acts of workplace violence are more likely to discuss the exposure, their feelings and other issues with peers or family but rarely report the incident(s) to university staff or ambulance service management. The objective of this study was to identify reasons for paramedic students not reporting exposure to acts of workplace violence.

Methodology

Paramedic students at Monash University who had been on ambulance clinical placements were eligible to participate. Third year students were invited to participate in an interview process whilst second year students were invited to participate in one of several focus groups. Students were asked two main questions, "what were the reason(s) behind you not reporting a workplace violence incident?" and "what process/processes do you think should be in place to encourage you to report the workplace violence incident(s)?". Responses for the first question were compiled into themes using thematic analysis whilst responses for the second question were collated.

Findings

Seven themes were identified from the focus group and interview process about why students did not report exposure to acts of workplace violence. The themes were: "fear of backlash", "don't want to upset chance of getting a job", "reporting will not change anything", "don't want name tarnished", and "lack/not knowing reporting procedure". The main points proposed by students to persuade them to report exposure to workplace violence acts were: "it needs to be anonymous", "done through the university", "confidential with follow up support", and "easy reporting process". The reporting mechanisms suggested by students included: "a phone app", "on line web page", "phone hotline", and "part of the clinical placement reflection book".

Implications for Education

Paramedic students need to be better educated about acts of workplace violence and why there is a need to report it. There needs to be a multi-functional anonymous reporting system in place to persuade students to report acts of workplace violence.

Learning objectives

Participants will...

1. understand the reasons why paramedic students do not report exposure to acts of workplace violence.
2. identify processes that would persuade paramedic students to report exposure to workplace violence acts.

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Violence Prevention Program and Standardized Training Curriculum Implementation: One Large Health Authority's challenges, successes, learnings

Sub-theme: Education and training

Paper

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Keywords: Education, training, policies, program

Background and context

Statistics from British Columbia, Canada show us that healthcare professionals make up approximately 11% of the workforce, but 57% of all claims from workplace injuries caused by violence are received from that 11% (WorkSafeBC. 2015).

The Fraser Health Authority in British Columbia serves more than 1.6 million people with an annual operating budget of 3.3 billion dollars. There are over 35,000 staff, physicians and volunteers. Service includes 12 acute care hospitals, 7,760 residential care beds and mental health, public health, home and community care programs.

British Columbia health authorities are mandated by WorkSafeBC and the Ministry of Health to ensure the presence of violence prevention policies, procedures and training. In January 2012 and again in April 2015, the Fraser Health Authority was "commended for its extensive and comprehensive work place violence prevention program" by Accreditation Canada.

Methodology

Multiple components are required for a complete Violence Prevention Program. An overview of Fraser Health's Violence Prevention Program components will be discussed including but not exclusive to the following: Violence Prevention Policy, Violence Risk Assessments, Workplace Health Call Centre, Regional Violence Prevention Steering Committee, Supervisory Skills Training, Provincial Violence Prevention Education and Training, and Violence Response Procedures and Training (Code White).

A quantitative and qualitative review of 5 years' worth of data and evaluations from the implementation of a new standardized violence prevention training program for healthcare will also be reviewed.

Findings

The combination of violence prevention program components have been positively acknowledged and passed the last accreditation process again for violence prevention. The combination of violence prevention program efforts, education, and support from all levels of the organization have shown definite positive trends. The following are successes and data from April 2015 to March 2016:

- An increase of 30% for reported violence incidents
- A decrease of 25% for total employee days lost
- An increase of 240% of employees completing individual online modules
- An increase of 131% of violence prevention core classroom sessions held
- An increase of 180% of employees completing the core classroom program
- An increase of 403% of advanced team classroom sessions held
- An increase of 400% of employees completing the advanced team classroom session.

Also upon initial review of training evaluations following the implementation of a new provincially standardized training program for violence prevention in 2011/2012, overall program reviews and feedback have been excellent. Training numbers continue to increase annually while increasing overall staff awareness of violence prevention. Training for staff working in the assessed highest risk areas, mental health and emergency, have reached an average of 96% completion across the region.

Future Implications

The Fraser Health continues to review, audit and improve organizational violence prevention policies and practices. The educational curriculum itself has recently undergone updates to ensure ongoing and current best practices with its provincial partners across the Province of British Columbia, Canada. Ongoing evaluation and updates to ensure inclusion of current best practices will be required. Staff training, educational support and overall training numbers continue to increase across the organization. Sustainability planning is ongoing to ensure ongoing successes by increasing trainer resources and maintaining ongoing communication with senior management for ongoing support and buy-in for the overall program.

Learning objectives

Participants will...

1. Become acquainted with policies and training components
2. Learn of recommendations for a successful violence prevention program. policies and training components.

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Exploration of the experience of bullying and the creation of an intervention model in nursing education

Sub-theme: Education and training

Paper

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Keywords: Workplace violence, bullying, nursing education, inclusion

Background

The discussion of bullying is not new to nursing. The consequences of workplace violence have been reported widely in the healthcare profession literature including its destructive impacts on mental health and well-being of healthcare providers as well as quality of care and working environment. Workplace violence and violence in nursing education is being identified in the literature as horizontal/lateral/vertical violence, bullying, or incivility. A number of efforts has been reported to reduce education/workplace violence. This paper will discuss the results of focus group discussion with students, a literature synthesis to explore the best models for bullying reduction or elimination, and the creation of a pedagogical model.

Methodology

Workplace violence was operationalized in this paper as bullying in nursing educational program including clinical placement. Electronic databases on nursing education, healthcare professions (psychology, mental health, social work, medicine, nursing, etc.) in relation to workplace violence/bullying and inclusive education were searched for abstracts and full-texts in English in the past 5 years. The most relevant articles were selected for analysis. Focus group discussions were conducted with graduating nursing students at York University on bullying and coping strategies in classroom and clinical setting. The discussions were transcribed and analyzed by the research team of the project. A pedagogical model emerged from the literature and the focus group analysis.

Findings

Bullying reduction strategies addressing bullying at individual levels were reported not as effective as expected. Instead, the strategies addressing bullying from management and structural level were confirmed to be effective. A model of inclusivity that includes an emotional intelligence approach and bias free framework emerged as a foundation of possible bullying reduction strategies.

Implications for practice, research, education and training

Improving the education experiences of students from a pedagogical approach has future implications for future nurses working environment. This study supports the creation of learning strategies to create safe learning spaces through the use of an evidence informed model.

This study's findings have implications for nursing education, nursing professional development, nursing administration, and nursing practice. The findings also contribute to the culturally diverse learning/working environment.

Learning objectives

Participants will...

1. have an understanding of the many forms of bullying.
2. understand how bullying is perpetuated.

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Five years later: Collaborative Revisioning of a Provincial Violence Prevention Curriculum

Sub-theme: Education and training

Paper

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Keywords: Curriculum development, adult learning principles, violence prevention education

Introduction

In March 2011, the development of a Provincial Violence Prevention Curriculum was completed by a provincial committee of violence prevention subject matter experts (SMEs) from British Columbia's Health Care Unions, regional Health Authority employers, and WorkSafeBC. The goal of the curriculum was to address inconsistencies in violence prevention training for health care workers by creating a provincially recognized, health care specific, multi-modal violence prevention education program. The challenges were great as British Columbia (BC), Canada's westernmost province, is made up of 7 different health authorities, which geographically covers almost 2 times the area of France, and has hundreds of health care facilities.

In the subsequent four years, the BC Provincial Violence Prevention Curriculum (PVPC) was implemented as the core violence prevention curriculum offered in BC's public health care organizations. Over this time, each health care organization adapted the curriculum to address their specific needs and service populations.

Methods

In 2014, a provincial committee reconvened to update the PVPC as BC health care stakeholders recognized the need to address "drift" which had occurred in the curriculum, such that the curriculum was no longer consistent between health authorities, and incorporate current research and facilitator experience. A project manager and coordinator led the curriculum revision process which consisted of:

- A literature review of violence prevention topics;
- Application of an instructional design process supported by education consultants;
- Incorporation of content recommendations by SMEs from the areas of trauma informed practice, dementia care and child/youth care; and
- An extensive process for piloting and evaluating the curriculum with frontline workers.

One of the initial steps in the revision process was to conduct a literature review to ensure that all content in the revised curriculum was evidence-based and augment the curriculum with information related to specific practice areas. A review of other violence prevention training programs, or programs which include a component of violence prevention, was also conducted.

Over approximately a year, the provincial committee met to agree on a set of common principles, an educational framework, and foundational skills and information that would form the core content of the curriculum.

Both the e-learning modules and classroom components were piloted extensively with front-line workers. They were both piloted on 3 occasions during the development process. Workers from all high-risk sectors as well as both clinical and non-clinical disciplines were included in the evaluation. The e-learning modules were evaluated through face-to-face observation, interview, and written evaluation forms. The classroom sessions were evaluated through written evaluation forms and one focus group.

Pilot participant and facilitator feedback was incorporated in each iteration of the online modules and classroom course which were subsequently reviewed by education consultants and the provincial committee.

Results

The newly revised curriculum builds on the original curriculum but employs an adult learning "flipped classroom" education model. This model emphasizes that the knowledge and information that staff need to

know for violence prevention is learned in 8 standardized e-learning modules, followed by an activity-based, 1 day classroom course where participants focus on applying the violence prevention concepts covered in the online content. The facilitators can spend their time in the classroom helping the staff apply and practice their knowledge in meaningful, realistic activities rather than lecturing to teach the information.

The classroom activities are led by the participants, who contribute experiences and scenarios from their work environments to direct the learning. For example, participants are asked to identify risk factors and stressors and develop a behavioural care plan for a scenario they develop based on a violent incident that has occurred in their program area. These participant led activities increase staff engagement and investment in the class by making the content practical and relevant to the work and situations they face every day in their particular area of practice, be it emergency medicine or dementia care. Any customization in teaching will be directed by classroom participants and supplementary information provided by facilitators specific to the health care sector and program.

The e-learning modules and classroom content are organized into an educational framework to facilitate participant knowledge retention and application. The framework was developed by distilling the content into foundational principles, and linking violence prevention and protection strategies into the following 4 responsibilities:

- **Recognize Risks and Behaviours** – This refers to the awareness and understanding of the general risks and behaviours which are associated with violence so that staff know what to look for when interacting with others.
- **Assess and Plan** – This refers to the informal and formal risk assessment of a particular person or situation, and the development of a plan to eliminate or mitigate the risks.
- **Respond to the Risk** – This refers to the application of strategies to prevent escalation, de-escalate violent situations, get help, and protect against physical violence.
- **Report and Communicate Post-Incident** – This refers to the post-incident processes for addressing the physical and emotional impacts of violence, communicating risks and interventions, and implementing safety measures to prevent future violent incidents.

All of the material presented in the e-learning modules and the classroom is presented in the same order and precisely follows the tasks and sub-tasks within the 4 responsibilities so that the learner is always able to connect the learning points and link the material between the modules and the classroom.

Key content additions to the revised curriculum include sections on the relationship between threat perception and brain function, and the Point-of-Care Risk Assessment (PCRA).

Understanding the relationship between perceived threat and conditions that affect brain function helps health care workers respond effectively to potentially violent situations by helping them:

- Recognize and understand their own limitations when interacting with escalated individuals.
- Identify and practice self-settling strategies to help them respond rationally and safely.
- Adapt their approach to account for the limitations of patient populations that have conditions that impair their threat perception, response and ability to self-regulate (i.e. persons with dementia, brain injuries, a developing pre-frontal cortex, trauma history etc.) so that they can avoid triggering them and help them to de-escalate.

Since most violent incidents occur at the point-of-care and often during care activities while staff are in a person's intimate zone, it is essential that the staff complete a quick, informal point-of-care risk assessment to ensure that it is safe to start, or continue, with a task. This involves a quick screening of the person, the environment, the task, and themselves, the staff member.

These 2 concepts form the basis for many violence prevention strategies and can be incorporated into everyday tasks and interactions under each of the responsibilities of the educational framework.

Discussion

The curriculum revision process was no small feat. As the project progressed, it became apparent that there were varied beliefs and cultures among the provincial committee members that affected how value was placed on different aspects of the curriculum. Coming to agreement among all stakeholders on the project goals and education delivery model was particularly challenging. In addition, the consensus-based revision process, regional differences in violence prevention education delivery and limited resources contributed to the complexity of the project.

The roles of the project manager and coordinator, and education consultants were key to overcoming the challenges of a provincial committee driven project. Facilitation and development support provided by the project leads enabled the provincial committee to focus on content development and reach consensus on politically sensitive issues. The education consultants provided an impartial perspective that mitigated conflicting provincial committee member views. They also helped direct the curriculum redevelopment so that it followed adult learning and instructional design principles and successful learning strategies. Based on the experience of revising the provincial violence prevention curriculum, the following lessons were learned:

- The importance of combining evidence-based practice with respect to violence prevention and sound adult learning educational principles.
- How a strong foundational framework to the curriculum can direct a working group with diverse views towards consensus.
- The advantages of a framework in linking together all the various components/materials of a curriculum in order for the learner to connect the information and make the linkages within the material.
- The importance of involving SMEs from various practice areas during the entire process – from information gathering at the beginning to pilot testing at the end. This process/input also helped direct the working group towards consensus on controversial issues.
- The various roles provided by education consultants – from the development of the foundational framework to the development of the curriculum materials to the development of the training manuals – to ensure that adult learning principles were being applied every step of the way.

Learning objectives

Participants will...

1. learn about the experience of and wisdom gained from revising a violence prevention curriculum including:
2. learn how to address challenges they may encounter in trying to develop an overarching curriculum while respecting local training needs.
3. learn of the benefits of incorporating an educational framework to a violence prevention curriculum and making education activity based, and participant led, through a flip classroom model.

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Failure to prevent violence: The social costs and consequences on women's health

Sub-theme: Education and training

Paper

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Keywords: Prevention of violence against women, Italy, social work, education and training, sector skill alliances, social and medical cost of violence

1. What can we do beyond dealing with the immediate emergency?

Addressing the problem of gender-based violence means analysing the related human and social costs, and also striving to provide suitable answers to a phenomenon, which, by its very nature, has been defined as “intense and pervasive”. A shamelessly open wound still today plaguing human rights that is in need of effective and practical remedies within a framework of policies for health and social care integration. Considering that the failure to prevent gender-based violence is a crucial issue in social policy, and that it is called into question by various fields of study (from medicine to sociology) in a partial or fragmented way, we can affirm the need for in-depth analysis and research from a gender perspective to highlight not only the consequences of both physical and psychological abuse, but also the causes and any possible solutions. In other words, the problem of violence against women requires a risk assessment, including of the consequences on women's health, and the adoption of both effective repressive and preventive countermeasures.

We are aware that overcoming the problem requires profound change within society and that this can only happen if supported by actions at various levels, ranging from institutional to private, and by targeted and synergic policies. We therefore support the need for an analysis of the health and social care costs resulting from said unsuccessful prevention, after which we can formulate certain hypotheses and proposals on prevention.

Our paper examines the situation in Italy, by analysing the so-called ‘Pink Code’ (a tag added to the color-coding scheme of the well-known advanced triage system) and the Centres for Non-Violence in two Regions, namely Tuscany and Sardinia. Our aim is to highlight the different professional styles in risk assessment and the reception of female victims of abuse, and to focus on the skills and tools available to healthcare and social professionals.

The ‘Pink Code’ and the Centres for Non-Violence (hereinafter PC and CNV) are not alternative services: they represent different moments in the provision of care and assistance and their users differ too. The PC is surely the most delicate phase, as the victim at the Emergency Room has not yet decided if she will be laying charges against her attacker/the perpetrator of the violence. A woman who turns to a Centre for Non-Violence has already chosen to pursue a path of awareness and personal change. It is important that a regular system of exchange between these services be set up, as well as the various stakeholders in the networks, which vary in terms of function and contents.

The PC provides a first insight into the phenomenon. Here, we can act without any significant increase in costs, because all we need to do is to provide professionals already working in emergency response with the necessary training, thereby generating human resources. The problem is how to network accessibility for female victims of abuse, as they frequently go to the emergency room of a city of which they are not residents to avoid being identified.

The CNV, on the other hand, which provides victims with solutions, has broader problems that are more difficult to solve, including management costs (the management of counselling services at the CNV and the management of women's shelters), and the means needed to ‘resettle’ and reintegrate women in a new environment. This implies a greater accountability and involvement of both formal and informal support networks. A CNV needs specialised and highly-qualified professional skills, in addition to specific social labour policies. This entails elevated tutoring costs and is not immediately productive.

To date, no other solutions have been provided; however, it is strongly felt that these two resources, the PC and the CNV, can be the launch pad for the development of an integrated health and social care policy for the future.

2. The social and financial costs of unsuccessful prevention

The data of the Italian National Institute of Statistics (Istat) (2015) on violence against women between the ages of 16 and 70 are known and worrying; however, there has been a decrease in the number of episodes and an increase in the number of reported cases and requests for assistance from available services and/or support at specialised centres in an 8-year period. A lesser-known fact is the cost of said phenomenon. According to a report 'What is the cost of silence' ("Quanto costa il silenzio?"), domestic violence against women in Italy has an estimated cost of approximately 17 billion Euros, divided into healthcare, pharmaceutical, social, legal, and psychological costs, etc. (Cfr. Intervita, 2013).

3. The Pink Code response

Until now, any available solutions were limited to social policy, whilst the healthcare sector was restricted to 'neutral' practices that treated physical injuries. The 'Pink Code' is a system of reception and protection that is activated once you cross the Emergency Room threshold. It is dedicated to victims of violence, abuse and sexual discrimination. In addition to medical care, patients have the right to psychological support in a private room. Healthcare professionals are trained to recognise the signs of abuse (which are frequently denied): "When they arrive at the Emergency Room, they do not say they are victims of abuse, but they might imply it, perhaps they hope someone will ask the right question. Therefore, we need a suitable form of reception on the part of healthcare professionals, but also on the part of law enforcement, or whoever comes into contact with a victim of violence. Working with a fresh set of eyes and knowing how to listen to the silences is key. This was essentially the turning point: succeeding in uncovering violence" (Regional Social Observatory 2012 p. 104). This service was launched as a pilot project by the local health authority (ASL) of Grosseto in 2010. It then became a regional project, and has been active in all hospitals of the Region of Tuscany since 2014. Thanks to this service, various institutions have been grouped under the same network, so that they can take action against a common problem, with different skills. The aim is to provide the victims of violence with a solution as soon as they arrive at the Emergency Room, and to offer more effective diagnostic tools and treatment, all the while guaranteeing their privacy and safety (Regional Social Observatory, 2012 and 2014).

A study launched in February 2016 and still underway (Biancheri 2016), which analysed the 'Pink Code' from the perspective of the healthcare workers involved in the project, has produced a provisional report on the strengths of the 'Pink Code'. These include:

1. restoring victims' confidence;
2. raising awareness and informing the general public;
3. restoring faith in institutions;
4. launching training programmes in schools;
5. building networks with other stakeholders;
6. developing bottom-up or in-situ procedures;
7. fostering synergy with the workers of Centres for Non-Violence and drawing upon their skills and experience;
8. creating a cohesive group, with shared norms and rules.

Thanks to the interviews carried out, we were able to obtain detailed information to be used for further research. We were also able to gather the stories of privileged witnesses, their interpretation and assessment of the problem and possible scenarios for the future.

A first indication of what we have learnt is given by the key words from the interviews, which have been grouped together in the word cloud below.

In conclusion, the interviews also revealed the four most important problem areas of the phenomenon, which also confirmed our theoretical approach:

1. the consequences on the health of victims of abuse and violence; the health-related costs of violence need to be considered;
2. the social and cultural dimension of the problem, with particular reference to resistance to implementing a different approach, for example raising public awareness;
3. possible solutions, including training which could be used as a tool to recognise both the acute and chronic forms of the problem, but also to foster synergy between the interoperational groups;

4. the implementation of the 'Pink Code' project, and the weaknesses of the healthcare workers themselves. These weaknesses can be attributed to problems such as recognising the phenomenon, the ensuing bureaucratic complications, available funding, privacy-related obstacles, and the challenges in maintaining and improving the project.

If we consider the problem from the perspective of the victims and if we consider what we have tried to reveal through our study, then once again we are compelled to reflect on how escaping that silent world of abuse and explicitly asking for help are indeed fundamental.

In this situation, psychological factors, personal cultural and socio-economic conditions, social factors and the characteristics of the local context play an important role. Being able to rely on an institutional network of support and protection can be a glimmer of hope for victims and can ensure, if not the elimination, certainly the containment of the phenomenon. Clearly, reporting abuse is the positive outcome of a path of awareness; but more stakeholders and institutions need to be involved, and they need to engage in an open dialogue and cooperate: from the Emergency Room to shelters, from law enforcement to social workers, from volunteers to healthcare professionals. A support system that involves the entire community is stronger, as are effective and efficient services and measures that are adopted to promote health and social care integration.

4. An Overview of CNVs in Sardinia: Areas for discussion from a recent monitoring programme

As recommended by the Istanbul Convention (CeSPI, 2013), in addition to the tools and actions adopted by the entire international community, we have a parallel process underway which involves the 'regionalisation' of the problem, i.e. of the means with which we can tackle it (D.i.Re – Donne in Rete contro la violenza, 2014).

One such tool is the establishment of CNVs and shelters (also known as a refuge or safe house), which in Italy date back to the early 1980s. They were set up as part of the feminist movement, within the broader framework of violence against women, perceived as a social phenomenon linked to the patriarchal family model. At the moment, there is no national law recognising the essential role of CNVs.

In Sardinia, Regional Law 26 of 12 September 2013 applies. It reads as follows: "*Actions to prevent and counter gender-based violence and stalking. Amendments and supplements to Regional Law 8 of 7 August 2007 'Regulations on the establishment of Centres for Non-Violence and shelters for female victims of violence'.*" Therefore, Law 8/2007 is the law governing the non-violence network in Sardinia.

In 2008, the Autonomous Region of Sardinia regulated the organisation and operations of:

- **CNVs:** facilities that perform the following activities: preliminary interviews to identify needs and provide preliminary information; prepare a personalised way out of violence to reinforce the victim's faith in herself and her abilities and promote a new and independent way of life; interviews of a legal, informative character; mentor women using public and private services, all the while respecting their cultural identity and freedom to choose;
- **Shelters:** facilities that receive and protect women and children from violent homes, in the framework of a personalised programme of recovery and social inclusion. They help victims restore their agency, while fully respecting their privacy and anonymity.

Since 2009, 9 Centres for Non-Violence and 5 shelters have been subsidised by predominantly regional resources in Sardinia. A consultation of the technical reports of the CNVs reveals that violence occurs more frequently in the home. As for the types of violence, in gender-based violence the aggressors are known to their victims. Indeed, regardless of the type of abuse, in none of the cases studied was the aggressor a stranger. This confirms the theory that the closer the relationship between perpetrator and victim, the higher the risk of being abused: almost all of the cases studied can be classified as examples of domestic abuse. After reading 5 out of 9 technical reports of the CNVs in Sardinia, the following problem areas were identified:

1. difficulty identifying in advance any cases of violence in different contexts: in the family, at school, amongst young people, through the use of social networks;
2. underestimating the risk of witnessing violence, something even those working in this field ignore;
3. the importance of working on prevention, both at schools and in families, to foster training and information exchange and thereby produce new forms of communication based on non-violent models;
4. difficulty for services to use an integrated method for receiving victims; the method should involve a planned way out of violence, that respects their determination and with which they agree;

5. weakness in handling any major issues, to be addressed during initial contact when a victim expresses all her doubts as to what to do next, before possibly laying any charges.

One way of improving the services offered is to adopt a continuous, active and effective planning process involving the entire territory. Otherwise, we risk implementing a project, which, although built around the needs of female victims of violence, will be fractured and separate from the territory. This, in turn, will make the implementation of reception projects and their long-term development, in particular, rather difficult.

Professionals volunteering their expertise and other workers tend to work at CNVs and shelters: psychologists, psychotherapists, educators, social workers, lawyers, counsellors and cultural mediators. The team tends to work together to develop, along with the victim, a new life development plan through individual work and networks (Piga and Pisu, 2016). The question is how can we create greater interest and participation in these networks, because, *in primis*, a network is necessary (the technical reports showed that only 50% of the victims were offered legal counsel; for the other 50%, a support system was provided throughout the legal proceedings. Special support was provided to women with children who had to appear in family court).

The role of networks is particularly significant when it comes to launching integrated social and employment programs for women who, based on their skills and past education/work experience can be incited to re-discover their self-esteem and secure job autonomy.

With a view to improving the services offered by the CNVs, we need to strengthen the staff, by providing (*inter alia*) a tutor who monitors activities and who offers psychological assistance to victims undergoing training or searching for a job. It is therefore important that we review the skills and territorial presence, in terms of numbers, of professionals operating in the sector, who are interested in promoting the coming together of numerous stakeholders searching for a solution to the problem.

It is difficult to safeguard the independence and self-regulation of the single components of a network and still guarantee their link to the CNVs. It is especially difficult to identify those responsible for governance together with social services, because, frequently, these individuals are volunteers or from the third sector with a mission, a vision and social autonomy, which do not always coincide with the dictates of a public body, i.e. the municipality and the region.

Overall, it would seem that all facilities offer personalised ways out of violence and legal services. They also organise events and awareness campaigns. However, it is worth noting that each Centre for Non-Violence is a hub of formal and informal knowledge, which needs to be analysed and studied from an empirical perspective, particularly because, thanks to the stories of privileged witnesses, we can identify solutions to be incorporated in social policy.

Without a doubt, the aforementioned Italian practices that we have analysed (centres for non-violence and the ‘pink code’) are merely a first response to the problem. They are well organised, but still not enough to counter the phenomenon. Nevertheless, they are the most important components of a network and the premise for teamwork characterised by “syncretism and contamination” and involving different professionals. They may well lead to a comparison of the cases to be handled, from a theoretical point of view (through training) and a practical perspective. They are a means to advance in a congenial atmosphere of planning, with the conviction that “we are doing what is right”, as underlined by those working in the sector, who feel motivated and engaged in a process of shared accountability for the problem of gender-based violence.

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Learning objectives

Participants will...

1. gain knowledge on the consequences of the failure to prevent violence especially on female social workers.
2. appreciate that a more holistic, gender-based and sector skilful alliance-based approach to preventing violence may be beneficial and enhance empowerment of professionals in the health care system.

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Using Technology in Simulation to Enhance Violence Prevention Training and Increase Caregiver Empathy

Sub-theme: Education and training

Paper

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Keywords: Education, empathy, simulation, training, violence prevention, de-escalation

Background and context

Education in de-escalation skills is a vital component of violence prevention programs in healthcare. Simulation provides participants with a safe environment to demonstrate competence in violence prevention strategies and allows instructors to evaluate student performance. Educators often search for ways to heighten realism in simulation to make training more relevant and meaningful. An equally valuable goal in training for healthcare providers is to increase empathy for patients. Empathic caregivers are known to decrease the potential for aggressive behavior in patients. In a large, public hospital in Seattle, Washington, educators developed de-escalation training using cameras mounted on patient actors. Students were able to observe de-escalation scenarios from the perspective of the patient.

Methodology

A simple framework guided simulation development. Elements of the framework included: audience, target behaviors, scenario script, and props needed. Scenarios were developed directly from incident reports of the prior year. To provide a more realistic environment, props such as fake urine and stunt weapons were used. Hospital beds and gurneys furnished a mock inpatient room. Instructors designed the scenarios with added complexity in order to evaluate situational awareness and to test participants' ability to prioritize. Small cameras were mounted on the patient actor's head and simultaneously projected onto a large television. A second camera was mounted overhead and projected on a nearby screen so observers could watch the scenario from two different perspectives.

Findings

All high-risk staff, those working in the Emergency Department, Psychiatry, and Security, attend annual, mandatory violence prevention training. Prior de-escalation training sessions had consisted of low-tech, low-anxiety scenarios. The addition of cameras caused reluctance in some participants; students were initially hesitant about being filmed. However, participants quickly recognized the value in being able to view clinical interactions through the eyes of the patient. Indeed, the first time students saw the situation from the perspective of the patient, there were murmurs throughout the audience. Despite initial misgivings, the technology enhanced de-escalation training was highly rated.

Implications for practice

Students are accustomed to living and working in high-tech environments. Increasingly, people use audio and video for everyday communications, especially younger individuals. As the cost of technology falls, training showing the patient perspective will be feasible in more and more venues. This model could be used by healthcare facilities in a variety of clinical environments to improve staff member empathy and decrease patient aggression.

Learning objectives

Participants will...

1. be able to describe the value of observing high-risk situations from the patient's perspective.
2. be able to develop a training scenario using a simple framework.
3. be able to evaluate how patient-perspective training could be used in their facility.

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TERMA – Therapeutic Management of Aggression

Sub-theme: Education and training

Workshop

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Keywords: Therapeutic Management of Aggression (TERMA), physical conflict management

Background

Violence in the workplace is regarded as destructive of quality in relation to healthcare and ranks threats to public health in line with HIV / AIDS issues, drugs, alcohol and tobacco (WHO, ICN & ILO 2002 Joint Programme on Workplace Violence in the Health Sector). Studies show negative consequences for victims of violence. In particular, this is shown through increased stress levels and reduced job satisfaction for workers.

TERMA consists of both theoretical and practical knowledge that can make workers better equipped to face aggression and threatening behavior from clients. To learn current theory and practical training in appropriate situations, will give staff mental models to operate from when aggressive episodes occurring. This will reduce the risk of injury to the patient and personnel. Focus in TERMA is largely directed against clinically active staff to gain an increased awareness of their own role in situations that develop in an aggressive direction. This means that the individual develops expertise in various alternative actions before, during and after an aggressive episode.

Methodology

Since the security psychiatric department in Bergen started up in 1989, the emphasis has been on developing a treatment culture based on ethical principles and evidence-based knowledge. This systematic work is reflected in the staff-training program TERMA.

Implications for practice

The participants will learn safe, ethical and effective skills and techniques for lowering and handling aggression.

Workshop presentation

30-40 minutes will be presentation of the fundamental principles behind the staff training program and the techniques. A demonstration of TERMA's physical conflict management will be given. The rest will be interactive participant involvement. There will also be some time for Q&A.

Learning objectives

Participants will...

1. get to know the fundamental principles behind the staff training program TERMA.
2. become familiar with a variety of physical techniques from TERMA.

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Simba – Simulation based training for staff working with aggression: A way to create safer workplaces by using Medical Simulation in psychiatry

Sub-theme: Education and training

Poster

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Keywords: Staff training, Team work against physical violence, Medical Simulation in Psychiatry, Participant involvement, Patient safety

Abstract

In several periods over the last 25 years the current form of training has extinguished and activity has been almost absent. The staff probably accepted that we work well enough without rigid plans. But training without adequate structure has been shown to provide more injuries and challenges than we can accept.

We started an educational action research study in 2007, used to develop our teaching structure (Garborg, 2009). Participation was the focus throughout the study. Democracy, active participation and learning to discover important knowledge yourselves were the pedagogic goal. Participants described in a log scheme what they found meaningful and what they wanted to learn more about, after every training session. Our education group analyzed the logs every fourth month, adjusting the teaching/training-program based on this feedback. Today 140 to 150 persons get this training 6-7 times a year. Every Tuesday 15 to 25 persons train in our training-center inside the clinic, in their planned workingtime. That makes this economical and easy to do. Nine t-t educated instructors deliver the training.

Methodology

Simulation (T-T-T, CRM and debriefing) and controlled feedback thru an educational action research study.

Findings

This simulation principles gives better team and individual preparations against violence, registering feedback all the time control that staff find the training meaningful and useful. Novices and experts train each other better, faster then before. Our three units work better together. The method makes it easier to share knowledge with other psychiatric institutions in our region. The staff feel safe enough to keep working with these patients.

Implications for practice

Every Tuesday Team training improves the chances for the teams to work better together. Staff from different units get to know each other. Cultures beat subcultures. Safe teams get higher tolerance for these patients unstable conditions. This also gives better patient safety. The staffs ability too discover and reqognize early signals of aggression increases, and they start to intervene earlier.

Most of the participants are reached by 6-7 training lessons a year. The education includes scenario-training, theoretical supervising, physical protection, De-escalation, and right use of Restraint. Medical Simulation in Psychiatry develops Staff's knowledge faster in our forensic unit.

Learning objectives

Participants will...

1. learn how this educational model (SIMBA) engages the staff, and their participation and thus secures their interests.
2. appreciate that the training is leadership grounded and develops knowledge faster between novices and experts.

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Optimum Student and Faculty Responses to a Unsafe Situation(s) during Home Visitation

Sub-theme: Education and training

Poster

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Keywords: Home visitation, Unsafe situations, Safety precautions, Student shadowing

Background

Home visitation programs are becoming more common in the US and across the globe. Appointments are usually arranged through a Home Care Agency or through a government-supported program. Community health nursing courses usually include student shadowing opportunities with trained and licensed home care visitors (HCV) for management of chronic conditions, pregnancy and aftercare, and wound treatment. As hospital stays shorten, more and more aftercare is being completed in the home. Not all home visits take place in safe environments. There have been recent incidences where students and HCVs have had to shelter in place due to events happening in the near-by area. Violence against HCVs is under researched and under reported, especially when students are present. However, the actual HCV knows that the potential to be a victim of violent crime is a very real possibility given the unpredictable situations in a private home.

Methodology

A literature search using PubMed and CINAHL will be completed for unsafe/violent situations during home visitation with and without students. Additional search terms will include field clinicians, violence in the home health industry, personal safety for home health nurses, student nurses and violence. A review of the current 2015 Occupational Safety & Health Administration (OSHA) Guidelines for Preventing Workplace Violence for Healthcare & Social Workers as well as any guidelines within nursing related to unsafe home visitation situations. Reference lists from each article will also be reviewed. Inclusion criteria: published within the last 10 years (2005-2016), peer-reviewed, statistical data present (if quantitative). Exclusion criteria: articles not relevant to nursing and/or healthcare, hospital or inpatient violence, and students not included.

Findings

Results will be shared pending completion of this systematic review. An evidence table will be provided.

Implications for practice:

There is already a nursing shortage within community health and it is expected to increase over the next decade. We must protect work environments in order to keep qualified nurses within the community setting. This review will provide students and faculty with up-to-date recommendations for handling unsafe situations as well as additional safety tips for protecting themselves during the visit.

Learning objectives

Participants will...

1. be able to recall data indicating a cause for concern about safety in homecare environments.
2. be able to list 10 safety tips for preparing and preventing unsafe home visitation events.
3. be able to discuss the importance of having a safe and stable work environment.
4. review the current recommended guidelines for preventing workplace violence for home care workers.

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Promoting tolerance of Israeli Jewish and Arab students of nursing

Sub-theme: Education and training

Poster

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Keywords: Tolerance, violence, nursing, students

Background

Israeli society is made up of many different groups. Jews comprise the majority population, when Arabs are the minority. Arab population is differentiated religiously, socially and culturally from the Jewish majority. In recent years, in light of political tension situations between Jews and Arabs, forms of intolerance appeared in wide range of actions from avoidance to hate speech in personal levels or via the social media among nursing students.

Methods

An education seminar was held for all students studying on first and second year at the nursing department of Max Stern Yesreel Valley College. The seminars aimed to counter intolerance in individual attitudes, to decrease ignorance and fear: fear of the unknown, of the other, other cultures and religions and to raise tolerance and acceptance. It provided them with tools for more tolerance and acceptance as individuals and as professionals in the future. Each seminar included five meetings for each group of first-year students and second year. Every meeting was attended by students from both ethnicity and lasted throughout the academic year. Each meeting was guided by one lecturer from the nursing department with an external dedicated expert. Quantitative and qualitative methods were used to evaluate this project.

Findings

225 students participated on the seminars 53% of them were Jews and 47% Arabs. The main results of the quantitative research included. No significant differences of student's attitudes between Arabs and Jews. Both reported that they are willing today to be more tolerance than before participating on the seminar, total mean score was 8 (on scale from 1 to 10), for Jewish student 8 and for Arabs was 7.7. They are willing to accept others more than before, total mean score 8, Jewish student mean score was 8, Arabs mean score 7.9. When there are any political tension situations, both groups reported that they will be more tolerant and less aggressive, at personal level or on the social media, Facebook for example, total mean score 7, Jews 6.7, Arabs 6.6. The mean score for process evaluating of the seminar was relatively low, mean score of 4 (on scale from 1-10). The qualitative research revealed to two main themes: the important and necessity of such educational seminars and negative attitudes for the process evaluation mainly due to technical problems. For example the timing of the seminar, or the fact that the seminar didn't have credit points. Demographic characteristics (gender, ethnicity, student year) weren't related to the attitudes of the students.

Conclusions

Nursing students Arab and Jews live and learn in multicultural society. They study together for four years, and then they will work together and with people from different ethnicity and different cultures. It is important and efficient to educate and work with nursing students to raise their awareness for the important of acceptance tolerance as human being and as professionals.

Learning objectives

Participants will...

1. understand the important of educating nursing students on the topic of tolerance toward and acceptance of other people who are different from them.

2. learn methods and get tools to promote tolerance and decrease violence among nursing students that will be health workers on the future.

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Nursing Students' Observations on Violence in the Community

Sub-theme: Education and training

Poster

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Keywords: Interpersonal violence, nursing students, education, observation

Background and context

The dimensions of violence made an essential the challenge which is organized, detailed and long termed for everyone. For nursing students, the Interpersonal Violence Management Course has been initiated and it contains that student gains knowledge and awareness about the generation, consequences, working with victim and prevention of all type of violence on the level of individual and societal, thus, having skill on violence management. In this presentation, student nurses' observations related to violence appearances in daily life will be analyzed.

Methodology

As a small project in the context of the course, students were asked to observe different kind of violent events in surrounding area and their observations were examined by the authors. During observations, they had to describe the environment occurred the violent event, its' types, consequences and reasons.

Findings

Of student nurses observations (n=13), most were from public places (street, public transport, park, school etc.). Two observations were based on health care setting. The most witnessed types were physical assault and psychological abuse. On the reasons, students stated various theories of aggression and they emphasized the multiple context of this untoward event. Students described consequences based on violent event as mostly negative and less positive.

Implications for practice, research, education & training, organisation / management, policy and guidance
To increase student nurses' awareness on interpersonal violence as a member of community, this pilot study will have implications both on the context of the course and individually. The integration between theory and practice will be able to provided through naturalistic observations from individual.

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Learning Objectives

Participants will...

1. gain knowledge about the Interpersonal Violence Management Course for student nurses from different culture.
2. learn of student nurses' benefits from the interpersonal violence management course.

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Staff injury reduction associated with pervasive Violence Prevention education across a large regional health Authority

Sub-theme: Education and training

Paper

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Keywords: Injury, violence, prevention, education

Abstract

Fraser health Authority (FHA), a large regional health authority in British Columbia Canada, has undertaken ensuring that every employee receives violence prevention education according to their role. Since 2006 all FHA employees have been provided with online education and all staff with direct patient contact were provided with four hours of classroom education. The curriculum is based in a trauma-informed and evidence based framework. For care providers in Mental Health and Emergency care settings, an additional eight hour Advanced Team Response course was provided. This study evaluated the efficacy of the Provincial Violence Prevention program in reducing the risk of injury due to violence among health care employees in the Fraser Health Authority.

The risk of injury of health care workers due to exposure to violence in the workplace has a large impact on the number of injury claims filed. In 2014 there were 206 injury claims due to violence filed by Fraser Health Authority employees amounting to 12% of all injury claims and a total claims cost of 56374. Important related concerns include psychological injury to staff and lost days of work.

The PVP program was developed to provide effectual training for all BC health care workers in order to reduce the risk of exposure to and injury from violence. Timelines for completion of this education have been set based on the acuity level of service area and related risk of violence. As the process of providing this education to all sites across Fraser Health continues, some sites have provided this education to over 90% of their staff while others, in accordance with timelines set, have yet to achieve substantive training levels. Violence related injuries continue to occur in both worksites that have achieved high levels of staff training and those that have not.

The study compares relative risk of work injury in work areas post-training to pre-training levels to ascertain efficacy and areas for improvement

Correlations between levels of staff education, incidence rates of violence and corresponding staff injury rates were tracked using a provincial reporting and analysis system across settings.

During the initial 4 years of the education program reporting rates of violence increased. As the percentage of staff that have received violence prevention education increases rates of violence have begun to decrease. Reported rates have been decreasing during 2016 as well as rates of worker injury and associated costs.

Effects of violence prevention education on reporting rates as well as the apparent necessity of reaching saturation levels of education may have important impacts on violence prevention and education policy and practice. Further research on the importance of educating sufficient percentages of teams is indicated.

Learning objectives

Participants will...

1. have an understanding of how large scale provision of violence prevention education can reduce incidence of violence and staff injury rates.
2. discuss how progressive levels of such education can have cumulative effects on rates of violence.

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Chapter 7 – Dialogue, policy and safety

This chapter encompasses presentations on the following sub-themes of the conference:

- Engaging with stakeholders in seeking solutions
 - Quality safety and risk reduction initiatives
 - Policy/guidance on best practice initiatives
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Clinician-Led Initiatives in Hospital Security: A Paradigm Shift

Sub-theme: Engaging with stakeholders in seeking solutions

Workshop

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Keywords: Hospital Security; Medical Direction; Violence Control and Prevention

Background and context

Hospital security forces are typically viewed as needed as a last resort solution to violence. Healthcare workers often perceive these forces in opposition to their mission of healing. We present a hospital security model with physician integration as a successful solution to many violence issues within the healthcare setting.

Methodology

We will present a hospital security model currently in use at an urban medical center campus that created a medical director position to work in combination with security forces and tactics to ensure safe delivery of violence prevention, control, and post-event review.

Findings

This model has been in use for over 2 years and allows for a use of force model which is clinically based on medical research and practice. A medical type peer review process has been applied to post use of force events as a result. There have been multiple successes with this program including withstanding reviews by governmental oversight agencies.

Implications

The model has implications for practice, research, education & training, organisation / management, policy and guidance: This workshop will be presented by the physician medical director and the chief of hospital security that developed this model to provide similar stakeholders with the necessary steps, materials and information applicable to set up a similar program.

How might your work inform similar initiatives in broader health service and/or geographical contexts?

For workshop presentations: This presentation is a paradigm shift for healthcare personnel to understand. Because it demonstrates a need to overturn typical security concepts within the healthcare environment, it is

guaranteed to generate a lot of questions and discussion because of its novelty as a solution for controlling violence within this environment.

Learning objectives

Participants will...

1. understand the need for establishing a Medical Director to provide clinical oversight for healthcare security operations.
2. comprehend the potential risks and liabilities of a healthcare environment security program that is not involving its clinicians in policy, procedure, and review decisions.
3. understand how introducing a Medical Director to serve as a clinical expert resource to a healthcare security program improved employee and patient safety and use of force accountability.

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Intra- and inter-professional relationships: Ethical impact on respect for nurses in internal medicine and surgical wards in the Italian context

Sub-theme: Engaging with stakeholders in seeking solutions

Paper

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Keywords: Ethics, healthcare facilities, intra- and inter-professional relationships, nursing, respect

Introduction

The concept of dignity is a multidimensional and intertwined construct. It has been debated and deemed controversial, with disagreements about its deep meanings. It has been described in different ways in theoretical articles, trying to explain this construct from different perspectives.¹⁻⁴

Dignity has been described as the basis of human rights, intrinsic to the worth of persons, but also associated with the social position an individual occupies in society.⁵⁻⁷ Human dignity can be described as innate, inalienable⁸⁻⁹ and also as social and relative, and thus can be bestowed or achieved by merit or status.¹⁰⁻¹³

Absolute dignity calls for recognition of an inner worth of every single person simply by virtue of being a person and can never be removed; dignity is 'incarnated' in persons.¹⁴

Social dignity, conversely, can be changeable and can be lost because of different social factors and moral behaviours. Under this light, dignity is defined as the capacity of behaving, to relate to others, and to make autonomous choices. Social dignity is considered as a value to be recognized by others, embedded in a time and a place and can be identified and expressed at various levels; it is conferred or gained by reciprocal actions in social contexts and is firmly based on relationships where each party enhances the other.¹⁰ Included in the concept of social dignity is the awareness of one's own personal dignity, implying recognition of one's own worth as a person.¹⁵⁻¹⁶

Dignity-of-self and dignity-in-relation¹⁰ are characteristics of the social dignity and are socially produced notions; both of them are contingent on the context^{10,17} of any situation and depend on cognition, emotions and comportments. In this way, the social part of dignity is in contact with the vulnerability of human beings and in our case, of nurses who at work are sometimes objectified, discriminated against and humiliated.¹⁸⁻²⁰

When considering the concept of professional dignity in comparison with dignity in general, many values expressed as basic in all health professions are touched upon, such as: altruism, accountability, excellence, duty, honour, integrity, respect for others, development of professional and social identity.²¹⁻²³

Aim of the study

The aim of this study was to describe and evaluate nurses' perceptions and experiences of professional dignity in the context of medical and surgical hospital environments in the Italian context.

Method

Design

A descriptive qualitative method was adopted as a research strategy. In this qualitative study we used a conventional inductive approach to allow new insights to emerge about the phenomenon under scrutiny.

Sample

The target group consisted of a purposive, convenience, non-probability sampling of clinical nurses working in medicine and general surgery departments and data were collected in public facilities in twelve Italian regions. The regions were selected from the north, centre and south of Italy to obtain heterogeneity of data.

Data collection

Data were collected using focus group discussions, in order to allow interactions among the informants. Every focus group had between five and eight participants. The staff was learned about the topic by a written information leaflet distributed by the main researcher on the day of the session. A semi-structured focus group format was employed.

Data analysis

The data were processed using a conventional, inductive content analysis starting from the information retrieved in order to extract meaning units, that is, 'the constellations of words or statements that relate to the same central meaning'.²⁴ (p.106) The data were transcribed and consisted of 12.429 lines and 413 A4 pages with 1.5 line spaces. A total of 1411 codes were reduced, connected together based on their similarities and differences, and abstracted to 49 sub-categories and 17 main categories. Seven connecting themes were found.

Results

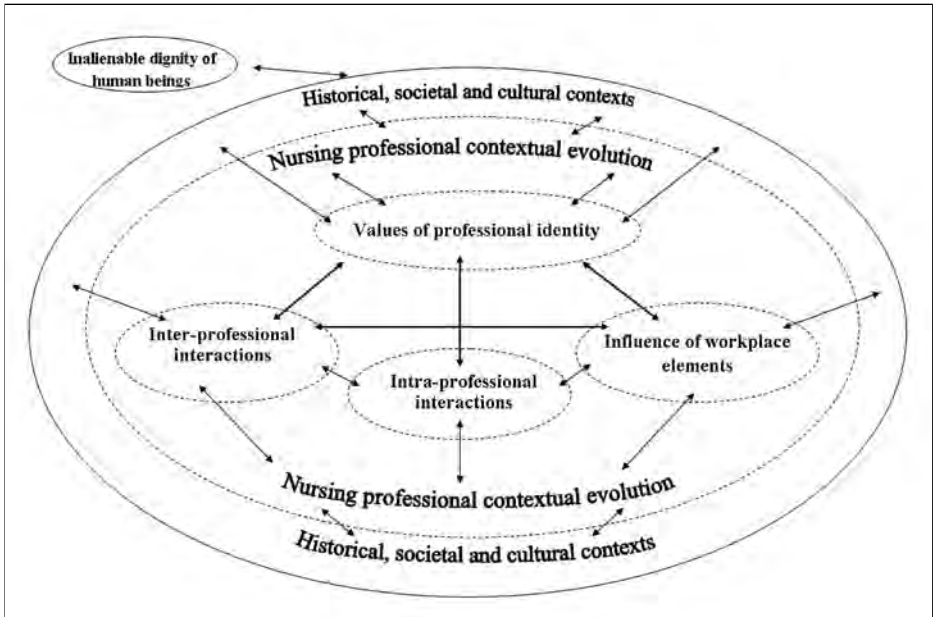
Once the data were analyzed and categorized, the perceptions of nurses working in medicine and surgery departments were grouped into seven themes concerning nursing professional dignity. The first four dimensions were:

- The inalienable dignity of human beings;
- Historical, societal and cultural context;
- Nursing professional contextual evolution;
- Values of professional identity.

The remaining three aspects were related to professional interactions and the influence of workplace factors and were represented by:

- Inter-professional interactions;
- Intra-professional interactions;
- Influence of workplace elements.

Figure 1: Nursing's professional dignity in internal medicine and surgery departments in hospital settings.



Discussion

This study provided insights into understanding nursing professional dignity in internal medicine and surgery departments in the Italian environment and enabled basic beliefs about it to be described. The construct examined was deeply embedded in the innermost part of individuals, which is the basis of dignity for every person. Especially concerning social dignity, great importance was given to the values that define nursing professional identity and to the socio-historical background and hence the evolution of nursing in the geographic area under investigation. The social part of dignity was linked to working with physicians and acknowledged as a key variable. The same could be affirmed for healthcare assistants who were thought to have a central role in easing the job strain and the burdens of patient care. Equally important, though, was the relationship with peers and, above all, senior nurses. Last but not the least, regarding the factors influencing nursing professional dignity, the pressure of workplace elements such as staff ratio, heavy workloads, excessive paperwork, etc.. was relevant as background to our close examination.

The agenda to realize a significant transformation in the delivery of healthcare is being motivated by the need to provide quality, affordable and sustainable healthcare. Healthcare facilities have the mission to improve inter- and intra-professional interactions in order to ameliorate the ethical climate and have better health outcomes for patients with useful cost-containment. Despite this, the collaboration among professionals is still an ongoing issue in the Italian hospital system where many environments are still stuck in an old regime.

The organizational environments included in our study, with their low staffing levels, time constraints, job exertion and overburden, did not promote respect for the dignity of the nursing profession. A defensive culture, even if aspects of innovation are visible, is still strong and measures to advance speedier changes of the situation should be put in practice. One of these could be to improve inter-professional education,^{25,26} which is as yet completely lacking in the Italian educational system, or to have the moral courage²⁷ to report, at least, the worst improper behaviours of healthcare professionals.

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Domestic Violence and the Health Care Workplace: the role of nurses' unions

Sub-theme: Engaging with stakeholders in seeking solutions

Paper

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Keywords: Domestic violence, psychological impacts, education and training, occupational health and safety, stakeholder engagement

Background

Canada's work on domestic violence and its impact on the workplace draws extensively on Australian research and their subsequent experience with implementing policies to address the issue. In response to concerns about the impact of domestic violence on the workplace, the Australian Domestic and Family Violence Clearinghouse was commissioned by the Commonwealth Department of Education, Employment and Workplace Relations to undertake the *Safe at Home, Safe at Work* project. The project sought to raise awareness among Australian unions and employers about domestic violence issues for employees and to promote the introduction of domestic violence provisions into enterprise agreements.

In 2011, the Australian government released its survey which looked at the prevalence of domestic violence, as well as its impact on the workplace. The Australian study found that 30% of respondents had experienced domestic violence defined as "an abuse of power by a partner, ex-partner or family member," which may take the form of "intimidation, control, isolation, and emotional, physical, sexual, financial or spiritual abuse." For nearly half of these workers, the violence affected their capacity to get to work. One in five workers (who experienced violence in the last 12 months) reported the violence continued within their workplace. Notably, nurses who made up a substantial percentage of Australian survey respondents, were significantly more likely (than others) to say that their coworkers were affected by the conflict and tension due to the domestic violence situation (83% versus 48%) and the survey surmises this may be the result of nurses working in open wards, emergency and health areas, and within teams [1].

Just under half of respondents spoke to someone about the violence at work, primarily coworkers and friends, rather than supervisors, HR staff or union representatives, and of these, most found that nothing changed or the result was negative. Of those who didn't speak to someone, the reasons given were privacy, shame, or fear of dismissal [2]. As such, the Australian data points to the need for employees to know their jobs are secure, and that there are workplaces policies and resources available, in order to overcome their reluctance to come forward and seek help from staff or union leadership.

This data underlies the fact that domestic and family violence cannot be marginalized as just a private or personal issue. When an employee is living with domestic and family violence, there are often very real costs and negative impacts that flow to the workplace, including health care costs and the cost of a loss in productivity, because domestic violence affects an employee's performance and may ultimately lead to discrimination in the workplace.

Therefore, aside from highlighting the prevalence of domestic violence and its impact on the workplace, the *Safe at Home, Safe at Work* project sought to determine the full economic cost. Figures from Australia (2008/2009) put the cost of intimate partner violence to the Australian economy overall at \$13.6 billion; this was predicted to rise to \$15.6 billion by 2021/2022; \$456 million of this would be borne by employers [3].

Working nationally with employers and unions partners, the *Safe at Home, Safe at Work* project was successful in promoting Australian awareness of the connection between domestic violence and the workplace. Moving beyond engagement and education, the project identified the need for standardized, non-discretionary and enforceable approaches by the Australian workplace, which would protect Australian workers experiencing domestic and family violence and help them stay in their jobs and in their homes. It promoted the introduction of domestic violence entitlements in labour awards and agreements.

As a result of this project, funded from 2010 until 2013, two million Australian workers now have domestic violence rights and entitlements as part of their negotiated workplace protections, including leave provisions and safety policies. New research, training and resources have been produced to enable employers and unions to understand and address the impacts of domestic violence in the workplace [4]. Many agreements are in the private sector, with a third of major private sector employers having family and domestic violence leave policies, including banks, airlines, big retailers, universities and telcos. The clauses have been extended to government employees in some states and Australian unions are pushing to have paid leave included in all awards [5].

In terms of legislation, the Australian government has provided for flexible work arrangement requests through the Fair Work Act [6]. The inclusion of domestic violence in the National Employment Standards will also require employers, managers, and human resources staff to be educated on how domestic violence can affect work so they can respond appropriately [7].

Preliminary Findings

In Canada, a survey undertaken by the Canadian Labour Congress (CLC), in conjunction with the Centre for Research & Education on Violence Against Women and Children at Western University, modelled on the groundbreaking Australian work, found that 33.6% (37.6% of women surveyed) of all respondents had experienced domestic violence in their lifetime. Among those who had experienced it, 53.5% experienced it at or near the workplace, 81.9% found that it negatively affected their work, 38% found it affected their ability to get to work and 8.5% lost a job due to domestic violence. Of those who experienced domestic violence, where it carried over into abusive acts at or near the workplace, abusive calls and texts were the main issues encountered. However, over 20% also experienced stalking/harassment near the workplace, and almost 20% had the abuser physically come to their workplace. Contacting of co-workers/employers by the abuser also occurred [8].

As a result of this kind of abuse, an employer might surmise that the worker is distracted and spending too much time on the phone, or on email, rather than focusing on their work. Therefore, the education of employers is critical, especially since research shows economic insecurity prevents women from reporting abuse to their employers and removing themselves from violent situations (fear of the loss of a job, loss of a house, etc.).

As nursing is a predominantly female profession, nurses have higher rates of domestic violence than other groups. Further, nurses work in public places, with ready access, as opposed to office workers, many of whom have some level of security in their workplaces. They need additional supports such as resources, collective agreement language and/or legislation to cope with potential impacts in the workplace. Currently, no nurses' unions have collective agreement language, and few have policies, materials, or supports for addressing the impact of domestic violence at work. Like other Canadian workers, few nurses turn to their unions for support.

This issue resonates with Canadian nurses, over 90% of whom are women. The dangers of domestic violence in health care workplaces were dramatically illustrated when, in 2005, a nurse who was a member of the Ontario Nurses Association (ONA) was murdered by an anesthetist – her ex-partner – who worked at her hospital [9], highlighting the fact that when an employee is living with domestic violence, there are often negative impacts in the workplace.

Over half of those surveyed in the CLC/Western University study were from the educational or health care/social assistance sectors. Drawing on the Australian model, the labour movement is taking steps to address this issue in Canada by a) educating the public/union members; b) influencing collective agreement language; c) lobbying for legislative changes. Aside from the very real potential for violence/harassment perpetrated at work, there are other consequences such as lower productivity, absenteeism, turnover and the potential for discrimination/stigma at work.

In terms of legislative change, progress is being made. Two Canadian provinces have proposed [10] or existing legislation [11] related to domestic violence leave and the workplace. The legislation passed in Manitoba, for example, provides for:

An employee who is a victim of domestic violence and has been employed by the same employer for at least 90 days is entitled to both the following periods of domestic violence leave in each 52-week period:

- *leave of up to 10 days, which the employee may choose to take intermittently or in one continuous period;*
- *leave of up to 17 weeks, to be taken in one continuous period [12].*
- *Up to 5 days in this 52-week period is paid leave [13].*

It is hoped that the proposed and existing legislation in two provinces will serve as a precedent-setting model for other provinces going forward.

In Canada, various unions are moving towards considering including domestic violence clauses in their collective agreements, basing their language upon the model language pioneered within Australian collective agreements. However, at present, few unions have clauses in their collective agreements that address the issue. The Canadian Federation of Nurses Unions (CFNU) is the lead organization implementing this agenda within the health care workplace as part of the broader issue of workplace violence, a growing concern for nurses across Canada.

Methodology

1. Develop with CFNU union negotiators basic principles and collective agreement language (e.g., time off, leave options, temporary leave, paid leave, protection orders, flexible hours, transfer and relocation, safety planning, security measures, etc.) and educational resources necessary to address the impact of domestic violence on the health care workplace.
2. Teach union leaders and stewards to recognize the signs of domestic violence and to help victims create a workplace safety plan.
3. Engage in train-the-trainer programs to disseminate information in order to build union training capacity.
4. Inform the training of Joint Occupational Health and Safety Workplace Committees so they can evaluate the risks/hazards of domestic violence in the workplace.
5. Help develop videos to educate employers/employees about the impact of domestic violence in the workplace.
6. Lobby governments to introduce additional legislation to ensure the protection of all health care workers, and all Canadians.

Discussion and Conclusion

The surveys undertaken in both Australia and Canada show that the percentage of those who have experienced domestic violence is similar in both countries. Further, there are also significant similarities in terms of domestic violence impacts on the workplace in both national contexts suggesting that Australia could serve as a model for Canada on this issue. While Australia has taken significant measures to address the issue both within the private and public sectors through concerted government, employer and union efforts, Canada's work remains in the preliminary stages and much more needs to be done to educate governments, employers and unions with respect to the impacts of domestic violence on the workplace. Australia's rapid success in obtaining rights and entitlements for workers impacted by domestic violence speaks to the great potential for change.

As a result of the preliminary findings of the survey undertaken in Canada, CFNU has identified the need to take the lead in addressing domestic violence as it impacts nurses in the health care workplace, a workforce and sector with specific characteristics (mostly female, public) that could increase the risks of domestic violence workplace impacts. CFNU has developed a methodology and will bring together relevant stakeholders (government, employers, unions) in this common effort to reduce the impact of domestic violence on the health care workplace. Going forward, CFNU will need to work with relevant stakeholders to further identify a) the special considerations related to the health care workplace with respect to domestic violence; b) the essential elements of best practices and successful strategies to support nurses in the workplace who are victims of domestic violence; and c) the specific collective agreement language and/or binding legislation that would be most effective in supporting victims of domestic violence.

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Learning objectives

Participants will...

1. acquire an understanding of the impact of domestic violence on workers in the workplace.
2. identify the elements of best practices and successful strategies to support nurses who are victims of domestic violence in the workplace.
3. learn about the importance of collaborative stakeholder engagement, including government, employers and labour.
4. learn about the pivotal role nurses unions can play in minimizing the impact of domestic violence on the workplace.
5. develop an appreciation for the importance of collective agreement language and/or binding legislation in supporting victims of domestic violence in the workplace.

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Broken Homes: Nurses speak out on the state of long-term care in Nova Scotia and chart a course for a sustainable future

Sub-theme: Engaging with stakeholders in seeking solutions

Paper

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Keywords: Long-term care, violence, bullying, aggression, health care, staffing, data, regulations, nurses, nursing, nurse practitioners, licensed practical nurses, registered nurses, support workers, funding, advocacy, campaign

Abstract

Over three quarters of Canadian long-term care (LTC) residents report some level of cognitive impairment and 31% suffer from severe impairment. There is a clear correlation between behavioural issues and violence against workers and between residents. The Nova Scotia worker injury rate in LTC is extremely high – over three times the rate of the hospital sector, with 42% more violence related claims overall, despite employing only one third as many workers.

The Nova Scotia Nurses' Union (NSNU) has been grappling with the issue of violence in the LTC sector for many years, and we presented on some of our work at the last Violence in the Health Sector Conference. The current presentation provides an important update as our work has significantly evolved following several key developments.

In January, 2016, the NSNU released a book on the problems in LTC from the view of front-line nurses and offered a series of concrete steps to help resolve them. The book reviews academic literature, the Nova Scotia context, findings from focus groups and from a fall, 2015 independent survey. The recommendations center on staffing standards, transparency and accountability, and the need for a comprehensive violence prevention program.

The book is the Union's key tool in a concerted lobbying strategy. The book was strategically released at a media conference shortly before government ministers were already due to meet press. Attention from the book has allowed the Union to secure important meetings with ministers, government officials and LTC employers. The desired result is the establishment of a multi-stakeholder group that will implement a comprehensive, evidence-based violence prevention strategy with measurable results. The book has been very well received by nurses, the public and many stakeholders, raising public consciousness on issues in LTC, including the alarming levels of violence. A thousand copies are being distributed. The release received extensive media coverage from every major television, radio and print outlet in the province. The Union President was interviewed live on several TV and radio broadcasts. Tweets related to the report were shared nearly 150 times and favoured over 100 times. Facebook posts were liked, shared and commented on more than 1,170 times, reaching approximately 43,500 people.

Responding to intense public interest, the Minister of Health has invited the Union to meet. Other key meetings have been planned, including a facilitated session with LTC employers, government officials and the Union, with the aim of finding common ground as we pursue a better LTC system for workers and residents alike.

The Union's work should have a direct impact on the delivery of LTC in Nova Scotia. The envisioned multi-stakeholder group, which already has in-principle buy-in from the key parties, will develop a common strategy to deal with violence in LTC. There has also been interest from other provincial nurses unions who wish to make use of our LTC research and strategy for campaigns in their provinces.

Learning objectives

Participants will...

1. learn effective strategies for engaging with a variety of important stakeholders.
2. learn about effective strategies for encouraging the participation of hesitant stakeholders.
3. have a better understanding of the level of violence and aggression experienced by nurses working in long-term care.
4. learn about the connection between staffing levels and violence.

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HealthWISE: a participatory approach to tackle violence and discrimination in health services

Sub-theme: Engaging with stakeholders in seeking solutions

Workshop

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Keywords: Workplace improvement, participatory approach, action and learning, collaborative solutions

Background and context

Health services are complex work environments, which can at times be hazardous. Violence against health personnel is a widespread problem. Unsafe working conditions may lead to attrition of the health workforce. Decent work in the health sector must include workers' safety, health and well-being, since the quality of the work environment can influence the quality of care. Often, health workers and health service managers have good ideas on how to improve the work environment and practices in their health facility, but are not sure how to approach the implementation of their ideas. ILO and WHO have jointly developed HealthWISE, a participatory and action oriented workplace improvement tool for health facilities. The goal of HealthWISE (Work Improvement in Health Services) is to provide healthcare facilities with a practical, simple, cost-effective approach to improve occupational health and safety and working conditions, performance, and quality of health care.

Objectives and methods

The workshop introduces HealthWISE, a workplace tool and training approach that enables health workers and health service managers to take action in improving the work environment. HealthWISE integrates various topics on occupational safety and health, personnel management and environmental health. Tackling violence, harassment and discrimination is the topic of one of the modules, thus integrating action on violence into a broader workplace improvement approach. HealthWISE promotes learning-by-doing, building on local practice; focusing on achievements; linking working conditions with organizational goals; and exchange of experience.

Implications

HealthWISE is designed for use by all who are concerned with improving workplaces in the health sector, including health workers and health-care managers, workers' and employers' representatives, labour inspectors, occupational health specialists, trainers and educators. It is particularly useful for health facilities in resource constrained situations, while applicable in every health service. HealthWISE encourages managers and staff of healthcare organizations to use proactive and collaborative problem-solving techniques to promote safe and healthy workplaces. Pilot tests have demonstrated that health facilities can use HealthWISE to empower employees to develop low-cost solutions based on local needs; enhance health management capacity; and encourage health worker retention.

Workshop methodology

The workshop consists of a mix of presentation, practical exercise and discussion.

- **Presentation:** Interactive introduction to the HealthWISE approach with particular focus on the topic of violence, harassment and discrimination.
- **Exercise/ Group work:** Participants will use the checklist - a workplace assessment tool - with their own workplaces in mind. They identify need for action, determine priority activities and will then develop sample action plans on how to initiate and sustain changes for improvement.
- **Discussion:** Groups report back to the plenary and a concluding discussion provides feedback on the tool and its use.

Learning objectives

Participants will...

1. realize that by taking action - everyone can initiate and sustain a respectful workplace.
2. appreciate that joint action - worker and management collaborative efforts work best.

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Reducing Emergency Department violence and increasing the patient care experience with a customer service focused Ambassador position

Sub-theme: Engaging with stakeholders in seeking solutions

Paper

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Keywords: Stakeholder, engagement, aggression, mitigation, de-escalation, customer focused, innovative, client services ambassador, positive interaction, 'soft'

Introduction

Violence in the healthcare industry in British Columbia (B.C.), Canada has received increased attention by government, labour organizations and the media over the past few years. In B.C. the healthcare industry accounts for 58% of all time-loss claims in the province caused by violence (Worksafe B.C., 2015). A review of the literature indicates that our experiences in B.C. are comparable to healthcare facilities around the world. Researchers in China (Yu *et al.*, 2015; Shi *et al.*, 2015), Turkey (Kocabiyik *et al.*, 2015), Finland (Lantta *et al.*, 2016), France (Touzet *et al.*, 2014), Jordan (AbuAlRub & Al Kowaldehy, 2014), to name a few countries, all describe the prevalence of violence against healthcare workers.

As Jacobson (2014, December) writes, "Health-care workers experience the most non-fatal workplace violence compared to other professions by a wide margin" (para. 2). York and MacAlister (2015) report that this enhanced risk of violence endured by health care workers has prompted several states in the U.S. to adopt specific legislation to help ensure a safer work environment in healthcare facilities.

The Lower Mainland Integrated Protection Services (IPS) program, which is responsible for security management for the four health organizations in the Lower Mainland of B.C., is all too familiar with the frequency and negative impacts of aggression against our healthcare staff. Our facilities are not immune to the increased risk of violence experienced by healthcare workers (Yanucil & Propati, 2015). Despite our best efforts to prevent and mitigate workplace violence through traditional security paradigms, we recently experienced a severe and high-profile assault suffered by a mental health nurse at the hands of a patient ("Hospital security guards not the answer", 2015).

In 2014 IPS reviewed aggression data and determined that, similar to other studies, the largest percentage of aggression incidents was occurring within the Emergency Departments (ED) of our acute care facilities (Touzet *et al.*, 2014; Fulde & Preisz, 2011). One prominent contributor to aggression is excessive wait times (Al *et al.*, 2015). Furthermore our data supported previous research indicating that a large proportion of aggressors were our patients (Magnavita, 2014) and that a large majority suffer from a mental illness (Phillips, 2016) and/or present under the influence of alcohol or drugs (Arnetz *et al.*, 2015; Rashed, 2014; Slijepcevic, 2014; Volavka, 2014). The results of our review and our current efforts to enhance the customer service orientation of frontline security officers led to the creation of a new role, called a Client Services Ambassador (CSA). This role was conceived as a more empathic approach to security in the ED, with the hypothesis that by being more engaging, customer service focused, less authoritative in appearance (CSA wears khakis and polo shirt), and proactive, we could contribute to reductions in aggression levels, improve staff perceptions of their personal safety, and reduce the need to call upon the regular uniformed security staff. This initiative is driven by the goal of reducing the exposure of clinical staff to aggression to allow them to focus on the highest level of care, contributing to a more positive patient experience. The CSA was implemented in the ED at three acute sites in B.C.: St. Paul's Hospital (SPH) [Vancouver]; Royal Columbian Hospital (RCH) [New Westminster]; and Surrey Memorial Hospital (SMH) [Surrey].

Methodology

The CSA role was designed as a net new security position dedicated to the ED, complete with a unique job description that was developed in direct consultation with clinical leadership groups. It was important to have this as a new position as opposed to supplanting an existing resource. The CSA requires enhanced training

in areas of customer service as well as completion of the same Strangers in Crisis training that all of our ED triage and registration staff receives (Institute for Healthcare Communication, 2016). This complements the provincial Basic Security Training (BST) as well as our organizational training requirements in verbal de-escalation and physical control and restraint that are part of the provincial violence prevention curriculum (Health Employers Association of B.C. [HEABC], 2016). The CSA does not write security reports, as is a requirement of the regular security staff at the sites, as the associated administrative time would impinge on time spent engaging with people throughout the ED, and is too reminiscent of a uniformed officer. The goal is to address the negative perceptions that many of our marginalized patients have towards those in uniform, particularly law enforcement and security. The CSA develops a personal rapport with many of our regular patients that fall within this marginalized population, learning their personal requirements and in many cases their specific triggers for aggression.

SPH saw the first incarnation of the role installed in February 2014. This initial role was limited in scope, focusing solely on the waiting area of the ED. A review of aggression data after four months revealed that less than 5% was occurring in the waiting area, and therefore IPS expanded the role to encompass the entirety of the ED. This study examines the impact of the CSA on aggression levels and staff morale at the three tests of SPH, RCH and SMH.

Because of their uniqueness, the researchers employed an independent-measures study design for each individual site. A dual epistemological approach was taken such that both qualitative and quantitative data were collected to evaluate the impact of the CSA on key dependent variables such as staff perceptions of personal safety and levels of aggression. We compared data pre and post implementation of the CSA. The exception was with SPH where the current CSA role is compared against the previous limited scope (wait room only) CSA role. The duration of the independent and control conditions for this study were six months each.

Quantitative data was obtained from two main sources. The primary source for comparing pre and post aggression levels was from the IPS Site Security Incident Reporting System (SSIRS), which is utilized across all facilities within the Lower Mainland of B.C. Key categories used for comparison were physical and verbal aggression. SSIRS data was filtered for the ED area only, and only for the 12 hours of the day that the CSA operated.

In addition to comparing aggression levels, IPS customized an i-pad application (QuickTap®) to allow the CSAs to document the frequency and type of interactions that they had with people in the ED. This included a specific item to capture the frequency of instances in which he/she successfully prevented potentially aggressive incidents that would otherwise not be documented due to absence of involvement of regular security staff. Using the QuickTap application, IPS created four categories of interactions: Customer Service/Hospitality; Health/Medical Support; Discharge/Social Support; and Behaviour Mitigation. Each includes several sub-categories. Specific to violence is the sub-category of Successful verbal de-escalation.

Qualitative data consisted primarily of staff surveys, using a 10-point scale of assessment of an individual's subjective perceptions of their level of personal safety. Surveys asked staff to rate how safe they felt from an act of either physical or verbal aggression during the 6 months prior to the CSA and during the 6 months the CSA was in effect.

Results

Overall, the impact of the CSA on aggression levels has been very positive. We looked beyond mere percentage trends to assess the statistical significance of the impact of the CSA on physical, verbal and total aggression at each test site. To do this we conducted independent-measures t-tests on the mean daily levels of aggression. The results are similar to the percentage trends, and thus provide further validity to the impacts of the CSA on the respective aggression measures.

Physical Aggression

We have seen reductions in physical aggression at all three sites for the current functional scope of the CSA. The largest improvements occurred at RCH, with a reduction of -38.8%, followed by SMH at -25.4% and SPH at -2.2%. The t-test results shown in Table 1 support the general conclusions drawn from the percentage trends, such that both RCH and SMH saw reductions in the mean daily physical aggression levels which were statistically significant at the $p < .05$ level. SPH on the other hand experienced a reduction that is not statistically significant.

Table 1: Results of independent-measures t-test on physical aggression levels.

Site	Control	Treatment (CSA)	t-test results
RCH	M = 0.84 SD = 1.09 N = 181	M = 0.51 SD = 0.84 N = 184	t(339.3) = 3.282, p < .05, one-tailed
SMH	M = 3.03 SD = 2.21 N = 184	M = 2.31 SD = 1.63 N = 182	t(343.09) = 2.97, p < .05, one-tailed
SPH	M = 1.92 N = 185	M = 1.90 N = 183	Not significant

Verbal Aggression

Verbal aggression levels decreased at both RCH (-13.2%) and SMH (-2.6%), albeit not as prominently as those of physical aggression. SPH unfortunately experienced a dramatic increase in verbal aggression of 28.1% during the CSA period, which requires further review for potential explanatory factors. The t-test results revealed that the reductions experienced by both RCH and SMH were not statistically significant. Only SPH saw the mean daily verbal aggression level during the CSA (M = 1.84, SD = 1.56) increase compared to the level prior to the CSA (M = 1.42, SD = 1.34). This difference was significant, t (356.87) = -2.768, p < .05, two-tailed.

Combined Aggression

Two of the sites saw combined physical and verbal aggression reductions that were statistically significant. RCH experienced an overall reduction in aggression of -30.9%, while SMH experienced a reduction of -19.5%. SPH was the only site to see a slight increase in overall aggression of 10.7%. Table 2 shows the statistical significance of the changes in mean daily averages of combined aggression for the three sites, respectively.

Table 2: Results of independent-measures t-test on total aggression levels.

Site	Control	Treatment (CSA)	t-test results
RCH	M = 1.22 SD = 1.28 N = 181	M = 0.83 SD = 1.10 N = 184	t(352.6) = 3.113, p < .05, one-tailed
SMH	M = 4.08 SD = 2.60 N = 184	M = 3.35 SD = 2.07 N = 182	t(343.09) = 2.97, p < .05, one-tailed
SPH	M = 3.35 SD = 2.30 N = 185	M = 3.74 SD = 2.10 N = 183	t (363.71) = -1.735, p < .05, one-tailed

Physical to Verbal Aggression Rate

It was important to examine whether the severity level of aggression changed as a result of the influence of the CSA. The lower the rate of physical to verbal aggression at a site, the less severe the aggression is in terms of potential for physical injury to staff. All three sites saw significant reductions in the rate of physical to verbal aggression. Despite seeing the only increases in verbal and total aggression levels, SPH experienced a reduction in the rate of physical to verbal aggression of -23.7%. RCH saw a reduction of -29.5% and SMH saw a reduction of -23.4%.

CSA Interactions

A unique aspect of this project design was the inclusion of interaction data to provide descriptive statistics relating to the multitude of interactions that the CSA had with staff, patients and visitors. Table 3 below displays the frequency of each interaction type. It is important to point out that these do not represent individuals, as the CSA may record more than one type for a given interaction with an individual.

Table 3: Frequency of interaction types

Interaction Type	RCH	SMH	SPH*
Customer Service/Hospitality	12,784	7,521	14,624
Health/Medical Support	322	132	899
Discharge/Social Support;	66	114	1,361
Behaviour Mitigation	1224	2009	3,867
**Successful verbal de-escalation	443	604	1,126
Total Interactions	14,396	9,776	20,751

* Numbers reflect 11 months (334 days) that the CSA has been in operation at SPH as of January 2016.

** This is a sub-category and the frequencies (443) are therefore included within the 1,224 for Behaviour Mitigation.

Staff Surveys

An important data source for this project comes from staff surveys of their perceptions of their personal safety while working in the ED prior to and during the CSA initiative. These surveys are the primary source of qualitative data, and provide arguably the strongest evidence in support of the success of the CSA project at all three test sites. Table 4 shows the results of the independent-measures t-tests conducted on the survey data.

Table 4: Results of independent-measures t-test for staff surveys

Site	Control	Treatment (CSA)	t-test results
RCH	M = 5.11 SD = 2.40 N = 18	M = 7.36 SD = 2.02 N = 36	t(52) = -3.627, p < .05, one-tailed
SMH	M = 6.73 SD = 1.87 N = 15	M = 8.42 SD = 1.51 N = 50	t(63) = -3.583, p < .05, one-tailed
SPH*	M = 5.05 SD = 2.11 N = 70	M = 6.54 SD = 2.60 N = 41	t(109) = -3.288, p < .05, one-tailed

* Survey for treatment period (i.e. CSA) was during original CSA period when limited to ED waiting area. Subsequent survey not completed for current CSA functional scope.

Discussion

The CSA role has re-defined the manner in which protection services engages clinical stakeholders in support of the management and prevention of aggressive/violent behaviour in the EDs in which it operates. This is consistent with the philosophy of IPS to support the provision of high quality care and positive patient experience by contributing to a safe and secure environment of care. We are seeing positive impacts not just on aggressive behaviour but in the overall morale of the clinical staff. This project is an attempt to address the concern associated with the reality that healthcare workers are at high risk for violence (Kim *et al.*, 2012; Jawaid, 2015; Jawaid, 2016). This is consistent with the study by Mistry *et al.* (2015) that found one of the prominent barriers to positive staff-patient interactions was excessive violence or abuse. The one element of the CSA role that makes it distinct from regular security staff is their direct participation in behaviour mitigation and discharge planning. The CSA participates in daily staff safety “huddles” at respective shift changes as well as formal clinical leadership “rounds”, to ensure they are fully debriefed on current patient population characteristics, including potential violence risks.

One of the factors that the researchers had to consider in relation to the interpretation of the data was whether lower aggression levels might be correlated with lower patient visits for the same periods. A review of the total ED visits reveals that in fact all three sites experienced increased visits during the period of the CSA. Therefore, based on available clinical data, patient visit levels do not appear to have had any appreciable impact on aggression levels.

There are numerous reasons why people choose not to report incidents of aggression, but it is nonetheless a reality of every health organization (Phillips, 2016; Touzet *et al.*, 2014). One unintended consequence

of the CSA project was that for the first time we are able to quantify, even if a mere estimation, just how much higher actual incidents of aggression are in the ED compared to the number of incidents reported to, and responded by, regular security. The use of the QuickTap i-pad application to count successful verbal de-escalations provided a unique quantitative insight into previously unreported levels of aggression in the ED. The frequency of successful verbal de-escalation interactions are a testament to the positive impact of the CSA in acting as a mediator and buffer to clinical staff allowing them to provide exceptional care thereby contributing to a more positive patient experience.

Staff surveys provided some of the most valuable data to this project. At all three test sites the mean score increased by a statistically significant amount when comparing perceptions of safety between the two conditions. The results reinforce the anecdotal evidence that IPS has received from all sites in the form of positive sentiments about the CSA role. One such example comes from a visitor who states: I am in Royal Columbian [RCH] ER right now (waiting for my son's broken arm/wrist to be examined), and the blue-shirt Paladin ambassador is working the crowd, getting people extra chairs, making them comfortable. It totally takes the "edge" out of what could be an anxious atmosphere. It's awesome to see your initiatives having an impact at ground level. Way to go! (Personal email correspondence, September 2015).

When analyzing the comments that staff provided on the surveys, a common sentiment that emerges is the request by staff to have the CSA operate on a 24 hour basis. Even at SPH where the aggression levels have not proven to have been significantly reduced during the period of the CSA, it was the perceptions of staff on their personal safety and the positive impacts to the overall morale of the department that ultimately contributed to the decision by administration for continued funding.

Notwithstanding the tangible successes seen as a result of the implementation of the CSA, there are limitations to this study that require mention. Foremost is the fact that the ED is a dynamic and chaotic environment that is not conducive to a strict empirical study design. Quantitative results are based on only a six month time period and therefore require additional time to validate current findings. As well, the i-Pad data is subjective and therefore vulnerable to user bias and usage habits. And lastly, the researchers recognize that survey response rates are lower than preferred in some cases, and vary quite significantly between sites and amongst the pre and post time-periods.

Acknowledgement

The complexity and scope of this project is such that it could not have succeeded without the direct support and participation of a multitude of people. We wish to express our sincere gratitude to the management and staff of the EDs, who eagerly supported this new role from the outset. Thanks to IPS PEPR for designing the study parameters and developing the associated data collection methods and tools. IPS Operations deserve specific mention for overseeing the ongoing management of the CSA initiative. Likewise we wish to recognize the tireless efforts of the management group of Paladin Security who are responsible for the day-to-day management of the CSA project, and for finding the best people for the job. And lastly, thank you to each of the CSAs whose actions and empathy ultimately make this project the success it thus far has been.

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Learning objectives

Participants will...

1. Understand that tackling aggression/violence in the ED requires stakeholder engagement.
2. Appreciate that solutions are often found by questioning traditional security models, i.e. status quo.
3. Understand that taking a customer service approach in the ED can lead to positive experiences for both staff and patients.
4. Understand that having the ambassador be directly involved in discharge planning can minimize negative behaviours from the patient.

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Joint committee response to a serious assault at an acute care regional hospital emergency department

Sub-theme: Engaging with stakeholders in seeking solutions

Paper

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Keywords: Serious assault, investigation, assessment, response, safety committee, union, management

Background and context

As a result of a violent assault of a nurse on March 1, 2015 in the Emergency Department at Abbotsford Regional Hospital and Cancer Centre (ARHCC), ARHCC established a Violence Prevention Program Review and Risk Assessment Working Group to conduct a comprehensive risk assessment as well as a broader assessment of the Violence Prevention program at the site. The working group membership includes site administration and managers, representatives from each of the healthcare unions, Workplace Health, Integrated Protection Services, and Access Health Abbotsford (AHA). This assessment was guided by WorksafeBC regulations as well as Ministry of Health requirements which stipulate that all healthcare facilities must have a Violence Prevention Program.

Methodology

A comprehensive review of policies, procedures, statistics, injury on duty reports, code white reports, special occurrence reports (security reports) and a topic-specific employee survey. In addition, 38 face to face interviews of Fraser Health, Intercon and AHA staff were conducted in person and by telephone. An environmental assessment of the department was done twice by members of the Working Group.

Findings

It is very clear that violence and aggression in the Emergency Department at ARHCC was a significant concern. The amount of employee input and feedback for this risk assessment was extensive. The comments made were detailed, insightful and emotional. As one of the interviewees stated, "Violence really does affect people, we lose really good nurses and the public doesn't know". While the level of concern is high, there are positive aspects to the assessment. The policy and procedure framework is in place, the Code White review process is a valuable monitoring tool, the violence prevention curriculum was designed for healthcare by healthcare workers and support from the manager and PCC's is good. The major concerns and associated recommendations were: Security, Department Design, Communication of Patient Risk Factors, Care Environment, Access Control, Training and education, and Duress Alarms.

Learning objectives

Participants will...

1. learn about staff responses to violence.
2. understand the challenges and opportunities involved in investigating, assessing and implementing recommendations arising out of a comprehensive review conducted by a Working Group of frontline and management staff and physicians.

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Organizational change: A case study of hospital staff attitudes, behaviors post amalgamation

Sub-theme: Engaging with stakeholders in seeking solutions

Paper

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Keywords: Attitudes, Behaviours, Organizational Change, Hospital Amalgamation

Abstract

To function with shrinking budgets, strategic planning often results in small hospitals amalgamating to form large health care organizations. Attitudes, behaviours, and interactions among staff during times of organizational change can have a significant impact on staff engagement, organizational performance, and patient satisfaction. These attitudes and behaviours can range from acceptance and support of the change to incivility and counterproductive workplace staff behaviours towards each other, the organization, and patients. The purpose of this qualitative, descriptive, single-case study was to identify Canadian hospital employee attitudes and behaviours to better understand the impact of an amalgamation. Qualitative interviews were conducted with six managers, six nurses, one physician, four administrative staff, and five other health professionals. Participants noted very few negative behaviours; management and physicians perceived the most positive impact from the change; nurses identified both positive and negative attitudes and only positive behaviours; administrative staff reported both negative attitudes and behaviours, in addition to the positive ones they identified; and other health professionals reported the most negativity related to attitudes and minor negative behaviours. The study identified specific attitudes and behaviours exhibited by hospital employees following a hospital amalgamation, in addition to pinpointing actions hospital leaders had taken to mitigate the negative response to the merger. These actions were targeted at preventing negative staff behaviours such as bullying, workplace aggression, and violence during times of organizational change via improved communication, increased stakeholder involvement, and creating a positive organizational culture to support and sustain organizational change.

Learning objectives

Participants will...

1. be aware of the positive and negative attitudes and behaviours exhibited by employees during periods of organizational change.
2. be able to identify actions health care leaders can take to decrease negative employee responses to significant organizational changes.

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Violence in hospitals – The needs of nurses and the ward manager's evaluations of the needs

Sub-theme: Engaging with stakeholders in seeking solutions

Paper

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Keywords: Hospital, violence against nurses, Ward manager, aftercare

Background

Violence against nurses is a common phenomenon in the health care system. In Switzerland the prevalence shows that about 50% of the nurses in hospitals are affected by physical or verbal violence of patients within one year of working. The aftercare of the affected staff is often unsatisfactory. There is a very low number of reporting of violent incidents, even if a reporting system is available. The consequences of violent incidents against nurses are diverse and far-reaching. The aim of this research is to investigate the needs of affected nurses and the ward manager's evaluations of the needs. A further aim is to detect if there are any differences between the aforementioned evaluations.

Methodology

Semi-structured interviews conducted with seven affected nurses and two focus group interviews were conducted with three ward managers each. The Interviews were analysed by thematic content analysis according to Braun and Clarke. All of the participants worked in a Swiss hospital at the time of the study.

Findings

There were six themes identified: „manage the situation“, „it bothers somebody“, „feel maintained“, „take care of nurses“, „to be thrown off course“ and „it was okay when I went home“. The needs of the affected nurses differ in some points from the evaluations of the ward managers. For example the ward managers evaluate their own role in the incident more nuancedly, while the affected nurses describe the consequences of the incident more complexly. All of the interviewees referred to the attitude of the institution and the team culture as very important aspects in dealing with violent behaviour of patients. The ward manager is a key player in the whole process from the incident to the introduction of further aftercare. Reporting systems are not known to the group of interviewed nurses. The nurses mention that reporting systems might be helpful, and that they wish to have the opportunity to report incidents. All Interviews showed that there are mechanisms in the wards which allow a sufficient aftercare, with the result that no further aftercare is needed by the affected nurses. If those mechanisms fail, there is the need of psychological reconditioning. It is the institution's task to provide resources and to be open about the topic. If the institution is not, violence against nurses might have further consequences such as quitting the place of employment or psychic strain.

Implications

The support from ward managers for affected nurses is essential to handle violent incidents. To that end specific training for ward managers in dealing with violence against nurses might be helpful. The communication and the collaboration in the interdisciplinary team could be improved by discuss the incident interdisciplinary. The implementation of a reporting system, regular further training, and internal concepts about dealing with workplace violence are also possibilities to improve the outcomes of incidents and to decline the prevalence.

Learning objectives

Participants will...

1. have a basic understanding of the mechanisms in the wards which allow a sufficient aftercare for affected nurses.
2. learn which role the ward managers assume in dealing with incidents of violence from patients against nurses.

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Risk assessment of violence at work involving managers of a public health system in Barcelona

Sub-theme: Engaging with stakeholders in seeking solutions

Workshop

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Keywords: Violence, Work, Occupational, Risk Assessment, Hospital, Managers, Survey

Introduction

The World Health Organization defines workplace violence incidents as those in which the person is subject to abuse, threats or attacks in circumstances related to their work, and can threaten their safety, health or welfare. Almost a quarter of the incidents occur in the health sector and 50% of health professionals have ever suffered some kind of violence.

Violence acts include verbal and physical aggression, agitation by patients because their disease and essentially requiring clinical approach. In the healthcare environment favoring factors, which often interact with each other, can be structural, organizational, social, and individual care related. Exposure to workplace violence may be associated with physical and psychological injuries, acute stress, lack of motivation and reduced productivity, and has an impact on the quality of care.

In 2010 the executive management team of a main health care provider of the national health system in Barcelona (PSMAR) approved the policy “Zero Tolerance” to prevent violence at work, proposed by PSMAR Committee for the Prevention of Violence at Work. The purpose was to ensure a safe environment that eliminates / reduces the risk of violence and aggression as reasonably achievable, with a commitment to advance measures and mechanisms to minimize the safety risks involved. Several actions were agreed including the risk assessment of violence against health care workers in the hospital and planning of several surveillance and preventive measures. As part of it, a survey on perceived violence towards health professionals in their area/unit of responsibility was carried out to all managers of PSMAR to establish priorities for intervention.

Methods

PSMAR is a public health provider located at the seaside of Barcelona (Spain), with a workforce of around 3.500 professionals, distributed in acute and long-term care, mental and primary health, health care training and research. The study population included all 175 managers/supervisors registered in Human Resources records.

An ad hoc online questionnaire was elaborated from a previous one developed in another hospital in the region. It included 23 questions distributed in two sections and 2 open questions for qualitative comments, on the perceived risk of violence, risk factors and most effective preventive measures in each manager/supervisor’s responsibility area. The questionnaire was previously piloted among members of PSMAR Committee for the Prevention of Violence at Work and a small group of professionals.

A combination of quantitative and qualitative analysis was carried out to define high risk and priority areas and potential interventions, according to services and activities.

Results

A total of 151 managers/supervisors completed the questionnaire, with an overall response rate of 86.3%, which was similar across main departments. Except one service, all PSMAR units and services were represented in the survey. Overall, 40.4% of managers perceived a low degree of violence in their area of responsibility, for 25.2% it was intermediate and it was high for 33.1%, and 22.5% perceived a low or very low level of safety in his/her area of responsibility. Proportions varied across groups, being the perceived level of violence higher in areas and groups of direct patient care, mainly nursing and nursing aides, emergencies,

inpatients wards, primary care and psychiatry. Low levels of safety were distributed similarly as levels of violence across areas and groups.

Main risk factors associated to a high probability of violence were long waiting hours (38.4%), patients' attitude (37.7%), care to psychiatric/addictive patients (37.1%), poor satisfaction with information (25.9%) and quality (23.0%) of care, and workers' attitude (21.2%). Other relevant factors associated to violence at work were staff reduction (19.2%) and dissatisfaction with the environment and equipment (16.5%). Other risk factors raised by managers were related to organizational issues (lack of safety personnel, equipment stability, etc.), structural (reduced/inadequate space, breakdowns of machines that hinder the pace of care, etc.), health care (home care, alcohol intoxication, etc.), environmental (night shift) and lack training and information.

Effective proposed preventive measures were mostly training of professionals in conflict management (57.6%), registry of patients/relatives associated with previous serious violent situations (43.0%), and improvement of care management (40.4). Other proposed measures were the availability of personal and/or area alarms (34.5%), cultural mediation (32.4%) and increased presence of security personnel (27.1%). Five groups of priority areas for intervention were identified, from high to low priority according to risk assessment, frequency, severity and time trends:

- Group 1: psychiatry.
- Group 2: geriatrics, emergencies, paediatrics, admitting service and inpatients wards (except morning shift).
- Group 3: surgery, otorhinolaryngology, intensive care, pneumology, internal medicine, gynaecology and obstetrics, and customer care.
- Group 4: neurology, radiology, oncology, rehabilitation, cardiology, digestology, haematology, urology, anaesthesia, traumatology, infectious diseases, neurosurgery, dermatology, nephrology, outpatients, radiotherapy, and endocrinology.
- Group 5: human resources, maintenance, schools, pharmacy, and occupational health.
- No priority (no perceived risk): pathology, thoracic surgery, executive management, rheumatology, economy, epidemiology.

Perceived risk factors and preventive measures varied among the 5 priority groups.

Discussion and conclusion

This is, to our knowledge, the first survey on workplace violence involving managers in a healthcare institution. The survey allowed the assessment of the risk of violence in work areas of PSMAR, based on the managers' capacity to contribute to the prevention of occupational risks in their area of responsibility, with the support of other specialised services and professionals in the hospital. The results of the survey show that violence at work is much higher in direct health care areas and to those caring for patients, although attention should also be given to other areas of the hospital. Within direct healthcare, nursing is the group that seems to be more exposed, as it is the emergencies department, inpatients wards, primary care and psychiatry.

Five groups of services/activities were established and ranked from highest to lowest priority according to risk assessment, frequency, severity and time trends perceived by managers, being psychiatry, geriatrics, paediatrics, emergencies, admissions and inpatient wards (afternoon and night shifts, together with weekends and holidays) the working areas with the highest risk.

Based on the assessment of risk, five areas of intervention were identified, for which risk factors and preventive measures that could reduce the risk more effectively were analysed. This information must be shared and agreed with each manager to organize preventive measures in their areas of responsibility, according to their relevance, effectiveness and feasibility.

The high level participation among managers (response rate of 86%), with almost all services and activities represented, ensures the representativeness of the results throughout the hospital and their usefulness for decision making.

In conclusion, the results of this survey responded to the need to evaluate the risk of violence at work at PSMAR, to increase awareness and involvement of managers in the prevention of violence at work in their area of responsibility, to develop and implement several actions and to conduct research on their effectiveness, to guide discussions with managers of high risk areas, and policy and development of related guidelines.

Based on the results of the survey, the Committee for the Prevention of Violence at Work raised the following recommendations to the PSMAR executive management:

- To develop and agree an action plan for the implementation of the preventive measures proposed by the managers, with their active participation and according to priority areas.
- To develop and agree a training plan for 2014 aimed at managers and professionals.
- To specify and implement structural prevention measures, such as personal and/or area alarms and safety cameras.
- To organize a focus group to discuss and define the measures related to healthcare management.

Acknowledgements

To Dr. Albert Marine, Occupational Health Service, Corporacio Parc Taulí: the questionnaire used in this study was an adaptation of the instrument developed by Dr. Marine.

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Learning objectives

Participants will...

1. have a basic understanding of a strategy for assessing the risk of violence at work in the health care sector.
2. have knowledge on how to measure the risk of violence using a combination of quantitative and qualitative methods.
3. understand how to prioritize interventions according to high risk groups.
4. be able to discuss about measuring the risk of violence at work and propose preventive measures by involving managers, and compare it with the assessment from the workers perspective.

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A Workplace Violence Prevention Summit: System partners collaborating to reduce the risks

Sub-theme: Engaging with stakeholders in seeking solutions

Paper

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Keywords: Collaboration; stakeholders; root cause; systemic

Background and Context

In 2014 workplace violence accounted for 11% of lost time injuries within the Ontario health care sector. The Ministry of Labour (MOL) noted that this resulted in direct system costs of nearly \$23.8 million. With over 200,000 workers in Ontario hospitals, varying opinions exist on how to address the causes and outcomes of workplace violence. In the past, stakeholders have had challenges in collaborating on workplace violence prevention initiatives. The idea of a summit was conceived as a means to facilitate discussion, to identify actionable solutions and root causes, and to develop strategies for violence prevention in hospital settings.

Methodology

On October 1, 2015, health system leaders including hospital, government, and union representatives came together at a workplace violence prevention summit hosted by the Ontario Hospital Association (OHA). In addition to welcoming remarks and a tone-setting presentation, a facilitated discussion allowed participants to work in small groups to address the following questions:

1. What are the root causes of workplace violence and what solutions/strategies have you used or would you propose be adopted in order to address the root causes?
2. What are some of the mechanisms that can be put in place to achieve the balance between clinical best practices and maintaining a safe and healthy work environment?
3. What barriers exist that impact your ability to further prevent workplace violence and what type of supports do you need in order to overcome the barriers?
4. How do we ensure that all stakeholders understand their responsibilities and are held accountable in order to achieve the best patient outcomes while eliminating workplace violence?
5. Other thoughts on how the OHA or any other organization can assist in addressing this issue?

To further refine and prioritize opportunities, participants were invited to complete a post-summit survey that captured and categorized a number of opportunities that could be pursued.

Findings

The outcomes of the summit were summarized in a report, broken down into the following key areas: Primary Conclusions, Root Causes and Barriers, Solutions and Mechanisms, and Steps Moving Forward. Short term, medium term, and long term objectives were also set.

Implications

This summit allowed stakeholders to engage in a focused discussion on approaches to preventing workplace violence. Through these efforts, key areas and objectives were identified. More importantly, stakeholders left with a better understanding of existing opportunities and barriers, as well as an awareness of how all parties will work together for a solution.

The information gathered at the summit is currently being used to inform the OHA's work and positions taken on activities of an Ontario Ministry of Health and Long Term Care and MOL Leadership Table on Workplace Violence Prevention in Health Care. In turn, this government table will shape next steps in maintaining the safety of health care workers while continuing to provide quality patient care.

Learning objectives

Participants will...

1. gain ideas on how to enhance communication with stakeholders.
2. appreciate how communication with stakeholders can ameliorate the mutual understanding of the challenge of aggression in the health sector.

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An Intervention Strategy to Reduce Work Place Violence in Healthcare Organizations employing the new assessment tools STAMP and SPIRAL

Sub-theme: Quality safety and risk reduction initiatives

Paper

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Keywords: Workplace violence, health care violence, STAMP (Start, Tone, Anxiety, Mumbling, Pacing), SPIRAL (STAMP assessment, Previous history of violence, Intentional/observed violence, Related to diagnosis, Aggressive behaviour, Law (record of criminal violence)), health care organization, nurses

Abstract

Workplace violence is a serious problem that affects nursing and other health care professionals in acute care settings. Evidence shows that violence has a negative and devastating effect on nurses by affecting their productivity, their psychological, mental, and physical health, and negatively impacts job satisfaction, commitment, and turn over. Furthermore, other studies show that violence impacts health care organizations; it affects patient safety, quality of care, and escalates health costs. The purpose of this paper is to describe educational strategies that focus on increasing nurses' awareness of potentially violent patients presenting in the Emergency room utilizing the STAMP (Start, Tone, Anxiety, Mumbling, Pacing) assessment. Patients with a positive STAMP assessment being admitted will trigger a SPIRAL (STAMP assessment, Previous history of violence, Intentional/ observed violence, Related to diagnosis, Aggressive behaviour, Law (record of criminal violence)) assessment, which consists six short questions. In addition, each patient admitted to the hospital will have a SPIRAL assessment completed. A high score will be marked on the patient's medical record with a special color, and will remain with the patient during their stay to enhance safety awareness of nurses and other health care workers. The educational training program will consist of a simulation video to train nurses on how to complete the assessment and de-escalating techniques. The training video will be developed as part of the collaboration between Indiana Regional Medical Center and Indiana University of Pennsylvania. The educational program will be evaluated based on pre-post knowledge scores, and if there is a decrease in the number of incidences involving physical violence. Moreover, this paper will highlight the importance of developing an institutional plan which helps in eliminating workplace violence, providing a safe and positive work environment, increased job satisfaction, productivity, and reduced turnover.

Learning objectives

Participants will...

1. have an enhanced understanding of the impact of work place on productivity , safety and performance.
2. have an understanding or the utilization of the STAMP and SPIRAL assessment tool to identify potentially violent patients in the emergency room.

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“Enough is not Enough” – Creating a safe environment on a mental health unit

Sub-theme: Quality safety and risk reduction initiatives

Paper

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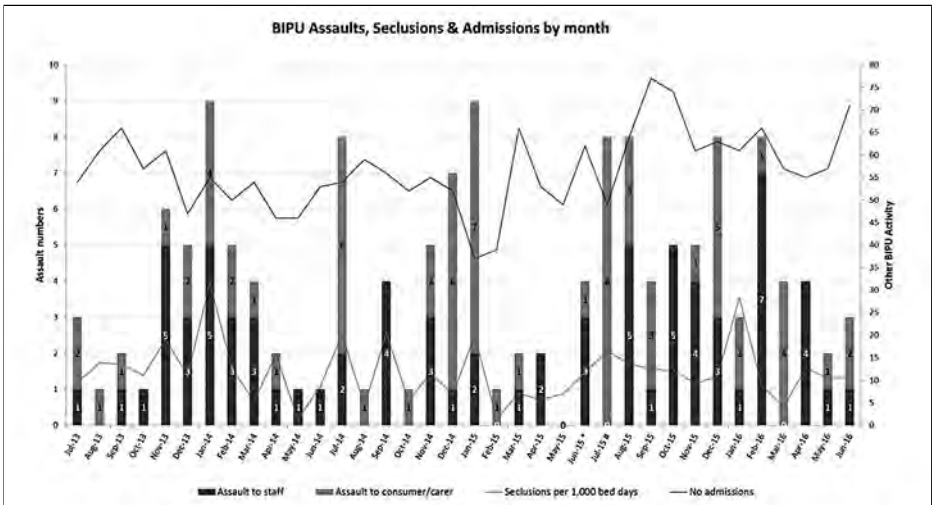
Keywords: Awareness, aggression, violence, causative factors, prevention, learning, safety

Introduction

North West Area Mental Health Service (NWAMHS) is a publicly funded mental health service in metropolitan Melbourne, Victoria, Australia and provides mental health services to adult consumers aged 16-64 years in community, inpatient and residential settings. In 2014, following a significant increase in the number of workplace assaults against staff, threats of violence and property damage in the In Patient Unit (IPU); NWAMHS decided “enough was enough” and formed a committee called ‘Creating a Safe Environment’ (CASE). The purpose was to ascertain and understand the circumstances leading to violence, by reviewing data, identifying themes from incident reviews, gathering feedback from staff and developing strategies on a patient and system level to reduce assaults and property damage.

Melbourne Health (MH), as the governing body of the NorthWestern Mental Health (NWMH) program inclusive of NWAMHS, has a whole of organisational “Safety First” strategy and imbedded into all policies and services, making the safety of patients, staff and visitors the first priority (Goodier, 2012). NWAMHS believes consumers, carers and staff have the right to be treated with respect, and without fear of abuse or assault. Underpinning this work is a culture where consumers, families and staff feel safe during service provision. Concurrently in Victoria over the past decade, there has been an increasing focus on Occupational Violence (OV) in the workplace (State Government of Victoria, 2005a; 2005b 2007; 2010; 2011; 2016 and Victorian Auditor-General, 2015).

Figure 1: Displays the incidents of assaults on staff by consumers, between consumers, from visitors aligned to the acuity of the unit with admissions and the use of restrictive intervention of seclusion over a three year period.



The Victorian Auditor-General (2015) “found shortcomings in all audited agencies. Despite an array of related initiatives ... the approach to OV against healthcare workers is neither strategic nor coherent”. This has been played out across many services where existing measures and supports are barely having an impact on incidents occurring; in fact they are increasing as the population increases and the demand for health services exceeds resources. In 2015 the Victorian Government passed legislation increasing the penalties on people convicted of an assault against emergency service workers including police, ambulance officers and emergency department staff (Parliament of Victoria, 2014). The risks faced by mental health workers have not been included. However, in consultation with legal counsel, theoretically the amendment extends to mental health workers if the assault occurs during an emergency intervention; NWMH is currently testing this legislation in the courts following the assault of two female senior nurses, described later.

Background to the service

NWMH is one of the largest publicly-funded providers of mental health services in Australia. A clinical division of MH, NWMH operates in partnership with mainstream health services to deliver a comprehensive range of specialist, Adult, Youth and Aged community and hospital-based mental health services to northern and western metropolitan Melbourne, Victoria which has a population of around 1.5 million people and a wide range of health and welfare organisations. As one of four adult area based mental health services, NWAMHS provides specialist care and treatment to residents of the cities of Hume and Moreland in the north western regions of Melbourne. The service employs multidisciplinary staffing of 210 EFT across five sites.

Figure 2: Map of NWAMHS catchment, Victoria



The NWAMHS catchment area is within a rapidly expanding growth corridor of Melbourne with expected population increase from 331,924 in 2016 to 445,061 in 2031; a 52% growth compared to an expected 39% growth of the Victorian population for the same period (State Government of Victoria, 2015). The area is made up of significant social disadvantage with high levels of unemployment, psychological distress, limited

housing, high crime and family violence rates within a very diverse multicultural community including large numbers of asylum and refugees immigrants. It also has one of the lowest beds per 100,000 capita in Victoria.

The profound impact and cost of violence in the workplace

The immense impact of Occupational Violence was recently highlighted in February 2016, when a consumer, during a two week admission, assaulted two female senior nurses. The following two accounts have been written by the nurses who were assaulted. They had a significant period off work, supported by senior staff and Return to Work Officer, have now returned to work on a supernumerary basis, still actively receiving counselling. The impact has been felt across the team, particularly with morale, however this has improved with their return to work.

Case study 1

"I am a Registered Psychiatric Nurse and was a victim of an episode of OV in February this year. I sustained 'two blows to my head' in an unprovoked attack. This occurred in the presence of team members and co-patients. Initially I did not recall much of the event after the 'first blow'. However, for whatever the reason I can recall a part of the assault with painful clarity as a female work colleague came to my aid and was punched in the head multiple times, she struggled with the assistance of other team members to stop him from continuing to assault me. The trauma from the assault and witnessing a work colleague being physically assaulted has left me with physical and psychological injuries that are far from healed. I would like to tell you 'I never cracked' and returned to work free from enduring damage, sadly this has not been the case. My family has been deeply affected by the assault, as they were not equipped to deal with the 'emotional aftermath' of witnessing me constantly crying when experiencing flashbacks. I went from being a person who would normally rise to life challenges, reduced to a person who was scared to go out in public places and initially frightened to return to my workplace. The raw emotional pain and suffering from an episode of OV is devastating and the impact from this event is with me every day as I go to work. I no longer 'feel safe'. The emotional 'fallout' has stayed with me long after the physical injuries healed"

Case Study 2

"I am a Registered Psychiatric Nurse. I have been involved in numerous incidents of OV during my career including verbal abuse, threats of violence, witnessed property damage and assaults. Over the past few months I have been physically assaulted twice which left me with anxiety, high levels of stress and constantly feeling in a state of high alert and dreading further outbursts. The impact is also felt throughout the team as I often see others struggling to manage a highly aggressive patient. It was during this time that I was physically assaulted by a male patient during a restraint. I was kicked directly in the face.

Upon returning to work another episode of OV occurred; a fellow ANUM being assaulted by a highly aggressive male patient who punched her multiple times in the face. During the struggle I was punched in the face, my glasses flew off and my lanyards were ripped from my neck. When on the floor during the restraint I felt additional blows to the back of my head. This event, alongside of the others, 'broke me, I could no longer hold my emotions in check as I struggled physically and emotionally'. This assault has robbed me of my self-confidence and self-worth as a person and a leader. Initially I could not leave my bedroom and experienced severe panic attacks when alone. My family and friends encouraged me to change careers. I withdrew from family and friends, I was too fearful to go out in public. I felt humiliated, ashamed, weak and unable to cope. I'm ashamed to admit in my darkest moments as I wrestled with emotional and physical pain I actually contemplated suicide"

CASE Committee

The CASE committee formed in February 2015 and ensured the service was collecting accurate data, reviewed, identified trends and common causative factors leading to OV. CASE Identified what other Victorian health and police services had done and spoke with staff to get their perspectives regarding contributing factors (Table 1).

Table 1: Contributing Factors to Occupational Violence - Perspectives from staff (n=1,755)

Environment	Infrastructure - inadequate furniture, fittings, limited space ICA beds
Treatment	<ul style="list-style-type: none"> • Inadequate screening of consumers effected by illicit substances • Limited use of consumer Safety Plans and Advanced Statements • Limited engagement with consumers • Review and follow up of consumers with history of assaults • Lack of purposeful activities • Prescribing medication and the use of PRNs
Leadership/training	<ul style="list-style-type: none"> • Medical leadership • Post assault of voluntary consumers • Shift leader role • Experience, skill and resilience of staff • Consistency of practice
Policy and systems	<ul style="list-style-type: none"> • Increasing release of consumer from forensic and prison early & directly discharged into acute mental health units, often untreated Introduction of "No Smoking" policy
Demand	<ul style="list-style-type: none"> • Increasing high acuity • Increasing demand for beds • Acute units working at capacity 7 days, yet only resourced 5 days

North West Area Mental Health Service

These initiatives resulted in the introduction of a number of measures, covering environmental, prevention, clinical interventions, leadership/system, training and incident management, with the aim of reducing incidents (table 2).

Table 2: Measures introduced to reduce Occupational Violence

	NWMH/Melbourne Health Response	NWAMHS Response
Environment	<ul style="list-style-type: none"> • Expansion and installation of CCTV into Adult In-Patient Units • Infrastructure and minor works • Successful \$1.7M submission with Department of Health 	<ul style="list-style-type: none"> • Successful trial of sand-filled – Norix Intensive Use Furniture • Refurbishment of Intensive Care Area (successful \$1.7M submission)
Leadership/training	<ul style="list-style-type: none"> • Review of mandatory Staff Training "Management of Clinical Aggression" (MOCA), focus on simulations • Acute Arousal Guidelines managing agitated consumers • Successful funding for Peer Workforce Model into units • Advocacy with the Department of Health for additional acute adult beds. • Revised expectations for medical leadership Implementation of "Smoke free" facilities. 	<ul style="list-style-type: none"> • In-house security guard • Redirection of increased forensic and drug/alcohol specialist support managing high risk patients • Funding for Nurse Practitioner Candidate focusing on safety • Prototype testing of Managers' Dashboard for OV
Policy and systems	<ul style="list-style-type: none"> • Managers' Dashboard for OV - • Guidelines covering Acute Arousal in managing agitated consumers • Pre and Post vention of OV, including reporting incidents to police and prosecution 	<ul style="list-style-type: none"> • Collection and analysis of incident data –Thematic and causative factors explored, with increased supports • Introduction of CASE Guidelines for staff including prevention, escalation and post incident management
Prevention	<ul style="list-style-type: none"> • Drug Detection Dogs as a deterrent of keeping illicit drugs on all wards • Actively screening of high risk consumers on admissions and at other times, including saliva drug testing, breathalyser and metal detectors 	<ul style="list-style-type: none"> • Installation of CCTV cameras in all units' public areas • Guidelines developed to support staff in reporting assaults to police • Patient safety and sensory modulation plans • Communication for Patients and Carers include a range of pamphlets, U Tube video, NWMH Drug Detection Dogs Initiative (NWMH, 2015), posters and information outlining safety measures

Conclusion

There is significant population growth in all NWMH catchment areas. This catchment area has increasing social disadvantage, increasing illicit substance use, increasing family violence, increasing crime rates, limited housing and limited social supports. This is occurring in a background of static resourcing.

Despite this, there is increased awareness, focus and strong leadership on the prevention of OV. With the introduction of increased screening, better identification and management of potential high risk consumers, supported by improved training and available pre and post supports, we are now seeing increased competencies and improved confidence amongst staff in managing consumers' agitation and subsequent assaultive behaviour.

State Government of Victoria (2016) released "Violence in Healthcare Taskforce Report – Taking Action to Reduce Violence in Victorian Hospitals" – as a report to the Minister for Health, in response to the Victorian Auditor General's report (2015). The report sets out ten (10) recommendations in addressing OV as a whole-of-health sector ensuring leadership and actions to be taken over the next three years. To ensure the effectiveness of these actions, clear key performance measures have been set, aiming to reducing OV incidents in health services.

The key initiatives and themes highlighted in this paper are now the basis for a calendar of work to be undertaken over the next 12 months across the NWMH, MH Network, led by the Network Executive.

Most of the initiatives implemented are applicable to other mental health services and across all inpatient units. The lessons learnt regarding supports, infrastructure and design are now being sought by other Victorian inpatient units. The challenges are significant and substantial, and to an extent, common to all publicly funded mental health services. However there is cause for optimism; with concerted effort and common purpose, significant improvements in reducing the incidence of occupational violence can be achieved.

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Learning objectives

Participants will...

1. gain a better understanding of causative factors leading to aggression and violence in mental health settings.
2. gain an awareness of strategies and options to assist in managing and reducing incidences of aggression in mental health services.

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What to use in an acute psychiatric ward? A review of available treatment for agitation

Sub-theme: Policy/guidance on best practice initiatives

Paper

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Keywords: Agitation, treatment of agitation, antipsychotics, tranquilizers, acute tranquillization

Abstract

Agitation as an unbalanced emotional state is very common in the psychiatric setting, yet its psychobiology is not well understood. Mental health providers frequently find themselves needing to manage patient in agitated state pharmacologically. Early pharmacological intervention play a significant role in breaking down the escalation of agitation. The drug that is intended to be used need to be effective, safe, fast acting, easy to be administered and patient-friendly. Antipsychotics, benzodiazepines and antihistamines are the main three anti-agitation drug groups. Understanding characteristics of individual anti-agitation drug help psychiatric staff select the most appropriate drug to treat agitation on spot. This article quickly review most hands-on drugs' characteristics and make a differentiated anti-agitation drug use guide.

Learning objectives

Participants will...

1. have a basic knowledge of variety of pharmacological treatment available for agitation.
2. have a basic understanding of how to select a treatment for agitation based on the drug characteristics.
3. have a basic understanding of using drug treatment as a strategy for reducing the use of seclusion/restrain on an inpatient psychiatry unit.

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Plan before you drive clients: Developing resources for an invisible problem

Sub-theme: Policy/guidance on best practice initiatives

Paper

Michael Sagar
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Keywords: Violence, automobiles, cars, home care, community care, group home, nurse, social worker, clients, transportation, video, bulletin, behavioural assessment

Introduction and background

Violence occurs in every facet of health care services. Much of the research and resource development has (rightly) focused on facility, and to a lesser extent, home based care. However, there is a segment of community-based care which involves transporting clients for a variety of reasons (e.g. medical, recreational, judicial, etc). Often these trips are not made with the same precautions taken to protect the safety of care workers who work in buildings. My department set out to determine if this was a widespread issue, and if existing resources would meet our stakeholder needs.

Incident 1: A community health nurse in a small rural town drove a client a short distance (<3 km) to a community appointment. During the trip the client assaults the nurse. The nurse suffers significant physical and psychological injuries.

Incident 2: A social worker is driving a client across a large bridge during rush hour. Halfway across the span, the client decides that he is getting out. The worker has to evaluate the risk to the person and themselves, and make possibly life-changing decisions in a few seconds.

Incident 3: A home care worker is driving a client on an errand in the community, when suddenly the person grabs the wheel and tries to crash the vehicle. Were these rare or “one off” events? Are there lessons to be learned from these incidents? What could have been done to prevent these incidents from occurring? The answer isn’t straight forward, and the source of this confusion is found in the culture, legislation and application of occupational health and safety in British Columbia’s health care and social services sector.

The Main Paper

British Columbia is Canada’s westernmost province, about the size of California, with 4.5 million residents, served by six large publicly funded health authorities, and a host of public, private and non-for profit care and social service agencies. About 285,000 people work in the health care and social service sector. These organizations offer a wide range of services, and may or may not provide transportation services to patients, residents and clients. WorkSafeBC is the body which both compensates injured workers and sets and enforces the Occupational Health and Safety Regulation (“Regulation”) for the province. They also develop injury prevention resources to encourage adoption of safer practices.

When conducting a systemic analysis of a workplace hazard, a first question is often: How big a problem is this? In this case the answer was unclear. Incidents of violence towards facility-based workers are widely known to be underreported. However, studies have not examined reporting rates for incidents of violence occurring in motor vehicles. Our search of published statistics found no counts or rates of incidents of violence which occurred to workers while driving patients or clients. However, during this review a few high profile incidents came to the attention of WorkSafeBC as a result of worker injury (these are summarized in the introduction).

Having no reliable evidence about the frequency of violence directed against care workers while driving, the next angle was about the expectations established by legislation. In British Columbia, the safety of workers in health care and social service workplaces is governed by the *Workers Compensation Act* (the “Act”) and the *Occupational Health and Safety Regulation* (the “Regulation”). A motor vehicle is included in the definition of a workplace in the Act. Curiously, motor vehicle incidents are been specifically excluded from the requirement to conduct an incident investigation when a worker has been injured. An unintended consequence

of this exclusion is that occupational health and safety requirements related to vehicles are often overlooked, resulting in a myth that workers who are driving as part of their work, especially if they are using their personal vehicles, are outside of the employers' obligations, and exempt from workplace safety rules. However, the Regulation has longstanding requirements for employers to assess and control the risk of violence against workers. While there is significant awareness of these obligations in acute, residential, community and home care, in practice, these requirements have only been sparsely applied to transporting people, and usually only for public transportation or ambulances. Professional codes of practice and accompanying professional standards have little advice on dealing with exposure to occupational violence, none of which is specific to driving clients.

In British Columbia, the primary obligation to prevent workplace violence falls to the employer. As with most jurisdictions in the world, employers also have a duty of care to the people to whom services are being provided. This duty is spelled out in case law, not legislation, and is therefore of a general nature. A review was conducted of the violence prevention policies and the driving policies of the large health care authorities, along with a small sampling of medium sized community agencies, to gauge how their driving policies addressed the issues of violence while driving.

None of the employers' driving or violence prevention policies that we reviewed extended to the safety of workers during the transportation of clients. The driving policies focused on having proper insurance (often showing concern about coverage for the client than the worker themselves), vehicle condition (including first aid kits, winter tires, etc) and a prohibition from distracted driving, where the source of that distraction was hand-held devices. None of the policies covered the possibility of facing violence during the trip, meaning that the potential for violence was never identified, assessed, nor were the workers given any instructions about how to deal with potentially violent situations.

The Industry and Labour Services department of WorkSafeBC conducts extensive outreach with health care and social service stakeholders, participating in about 70 events a year. During 2013/14, at each of these engagements, we started asking specific questions to the people that we met: "Do you drive clients as part of your job?" and "If so, have you ever experienced an incident of violence, while driving?"

The people that we talked to fell into three categories: those who didn't drive clients (a significant majority), those who did drive clients, and those who didn't drive clients, but supervised those who did.

What we heard shocked us. We learned that far more workers drove more clients, for a wider range of reasons, more often and for longer distances than we had expected. And every driver that we talked to had a story of at least one specific incident that personally happened to them. The incidents relayed to us were invariably of potential high risk for the worker, the client, or both. Universally, none of the situations or clients had been assessed for the suitability to make a trip. The value of trips was not weighed against the risk. None of the incidents were formally reported to the employer, none were investigated, and no corrective actions were taken as a result.

Conversely, when we talked to people who supervised workers who drove clients, they generally had a completely opposite outlook. They weren't aware of any risk, had never been told about any incidents, and generally questioned the value of our enquiries. They felt that this was a non-issue. We learned of a few organizations which had prohibited their workers from driving clients. In each case, the prohibition was based on specific incidents.

The incidents that were described to us could generally be put into one of three basic categories: a straightforward assault of the driver, an attempt by the client to crash the vehicle, or an attempt by the client to leave the vehicle. We felt that there was value in providing some direction to organizations about what type of incidents could occur to their workers while driving, and how they could improve their driving and workplace violence policies.

We conducted an online search, to see if we could find existing tools on how to assess clients and how to determine the relative risk of driving a client in the community. We found nothing that directly addressed this issue. We decided to develop our own guidance, not to prescribe what safe practices are (as we had no evidence to base this on), but to list factors to consider when planning a trip. A traditional OHS hierarchy was used to structure an assessment which were based on five factors to consider when deciding whether to drive a client, and what to do when it has been determined that a trip should occur.

Ultimately two resources were developed with similar content, one in the form of a bulletin, the second as a video, in conjunction with both violence prevention and occupational driving experts. The content of these resources was based on asking a series of questions to determine whether a trip is advisable, and if “yes”, then to plan ways to minimize the risk while making the trip.

Questions to Ask Before Driving a Client

1. Are there alternatives to driving?

- Make clients responsible for their own transportation
- Bring services to the client
- Accompanying the client, while using another driving service (bus, taxi, etc.)

This question is not asked nearly enough by agencies who focus so strongly on the benefits of a trip that they ignore the risk to their worker’s safety. Using alternative services cannot be done solely as a means of transferring risk to another agency. Privacy laws in British Columbia require disclosure of known risk of violence when transferring the services for a person from one organization to another. There are larger public policy discussions that need to occur related to this topic, as many care workers end up driving their clients as there are no practical alternatives to get to important appointments, etc.

2. Has the client been assessed?

- Using existing knowledge of the client
- Possible reactions from trip-related stressors

Within a facility, working with a person with known risk factors for violent behaviour should trigger an assessment or a plan when a new activity is being considered. Too often that doesn’t happen when deciding whether or not to drive a person.

3. Is the vehicle appropriate?

- Roadworthy
- Appropriate size and configuration
- Barrier needed?
- Loose objects removed

Generally the condition of cars is not a significant consideration, although many personal vehicles are not ideal for transporting people with significant physical needs. The most contentious issue related to this question is the installation of barriers. In British Columbia barriers are not commonly found in public transportation (buses and taxis), and some clinicians do not want to consider installing physical barriers over concerns over what they feel is labelling and restraint of their clients.

4. Is there a plan for the trip?

- Best time of day
- Number of people at minimum
- Safest route
- Criteria for cancelling a trip
- When to use a second worker

Very often the destination of the trip limits the flexibility of timing and route of a trip. Using a second worker as a form of protection of the driver was suggested by many drivers, but there was often little understanding of the conditions where this would be beneficial and what that person’s role was. Strong feedback was received that the organization needed to give the potential driver the option to cancel the trip for any reason, without questioning. Many felt pressured to drive clients in situations that felt unsafe, even before they got behind the wheel, as the perceived value of the trip to the client was viewed as being of greater value than the safety of the worker.

5. What happens if...?

- Motor vehicle crash
- Vehicle breakdown
- Behavioural issue

Most organizations procedures for their workers to follow if something happens to the car during the trip, but few offered their workers any advice as to what to do when dealing with behavioural challenges, including

when to intervene, when to get out and when to call for help. We talked to workers who were advised to contact their administrative office even when an emergency call to 9-1-1 would be a more appropriate response.

Conclusion

A survey of people who viewed the video confirmed that this is an under addressed issue for front line workers in the home and community sector.

Anecdotally we know that more WorkSafeBC inspecting officers are raising the issue of violence when driving clients during their inspections. This has led to more discussion among community-based care providers about their practices when driving clients. Whether these discussions will lead to fewer incidents will be impossible to determine, as there is no baseline of information.

Both the bulletin and video were subsequently adapted for use in schools whose workers face virtually identical challenges when transporting students.

References

Video: “Plan Before You Drive Clients: Reduce the Risk of Workplace Violence” (running time: 3 minutes)

Bulletin: “Reducing the risks when driving clients”

Both available at www.worksafebc.com

Learning objectives

Participants will...

1. Be made aware that transporting clients by motor vehicle carries a risk of violence that needs to be assessed as part of the planning of a trip.
2. Understand that there are resources available to help them make the decision about whether it is safe for a worker to drive a client.

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Creating a Safety Placard – Preventing and managing threatening and violent situations together

Sub-theme: Policy/guidance on best practice initiatives

Poster

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Keywords: Safety placard, violent situation, zero tolerance

Background

Tampere University Hospital is going through a major developmental program. A new Centre for Children and Adolescents is being built and by the year 2020 all existing child and adolescent departments from both somatic and psychiatric fields will move in. The staff has raised a concern in both patient and work safety regarding psychiatric patients moving into same center with children with somatic illnesses. The risk factors of violent encounters raise fear in working life. Psychiatric patients cause more fear in staff than other patient groups in general. Awareness and knowledge reduce fear and support controlled professionalism even in difficult, challenging situations. Zero tolerance policy minimizes unwanted behavior and creates a feeling of safety. Preventing violent situations from escalating also improves patient contentment.

Methodology

Evidence-based Practice Team (EPT) set a goal to provide staff with information and tools for preventing and managing threatening and violent situations at work. A literature review produced useful and encouraging information. Based on best information found the team created a placard and sent it for a trial to all units for further comments. Organizational adoption and implementation will continue by organizing training sessions in all units.

The aim of the Development Project

Work safety can be improved by regular training, distinct instructions and guidelines. Simply improving knowledge does not necessarily improve practice. It is important for patients and visitors to be aware of the organization's safety culture. The aim was to provide all staff members, patients and visitors with comprehensive, easy-to-read instructions in how to manage a threatening or violent situation. Creating a mutual understanding provides not only a tool for violent situations but it also supports a sense of community and work satisfaction.

The description of the Development Project

The safety placard utilizes AVEKKI practice model. The acronym AVEKKI comes from first letters of the Finnish words: aggression, communication, prevention, development, education and training. The model emphasizes the professional, appreciative and respectful confrontation of the patient while taking into account self-determination and patient orientation. AVEKKI-model approach is a process which proceeds from prevention, through various levels of management to debriefing. Visually these stages are indicated by three colors of traffic lights which are also used in safety placard. Green zone indicates a basic situation, in yellow zone the situation is already threatening and/or challenging and red zone indicates alert in highly challenging situations.

Findings

Clear protocols are necessary but often neglected. There was no example found of a placard for a hospital setting which would tell in simple few words how to react and what to do in threatening or violent situations. Safety placard when observable to all participants supports utilizing zero tolerance approach.

Learning objectives

Participants will...

1. appreciate that awareness and knowledge reduce fear and zero tolerance policy minimizes unwanted behavior and creates a feeling of safety.
2. recognize that Preventing violent situations from escalating improves patient contentment.

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Shifting Mindsets: The biggest Canadian nurses' union campaigns against workplace violence as not part of the job

Sub-theme: Policy/guidance on best practice initiatives

Workshop

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Keywords: Violence Prevention, 'Culture of Safety' versus 'culture of silence', Not 'part of the job', Cuts to RN positions, Underfunding, Increased patient acuity, 'Security as part of the circle of care', Leadership Table

Background and context

More than ever before in our history, nurses around the world must act on the call to fulfill our social mandate of political advocacy. It is our obligation as care providers. Advocating for our clients is a core value. Advocacy has been part of our skill set since our origins. As the largest nurses' union in Canada, the Ontario Nurses' Association is not just committed to improving the economic welfare and quality of work-life for our members. The outcome is to enable them to *provide high-quality health care*. Our vision is not just our commitment to our members. It is to members *who care for people...*

Because nurses know. We bear witness to the ebb and flow of the human condition. In moments of joy and celebration. In moments of pain and fear. In the beginning. And at the end. We bear witness to the breakdowns in our health care systems. We bear witness to misplaced priorities. We bear witness to struggle and injury when staffing and resourcing is too meagre to cope.

Nurses know. And knowledge is power.

An Angus Reid Public Opinion poll (2012) revealed that in Britain, 93 per cent of respondents have "a great deal of respect" or "a fair amount of respect" for nurses—a view shared by 96 per cent of Canadians and 92 per cent of Americans.

So how did our power originate?

In Canada one of the first "nurses" was a woman from Langres France. She landed in what is now Montreal, Quebec in 1641. Jeanne Mance established one of the oldest hospitals in North America, the Hôtel-Dieu de Montréal. Our first nurses were rooted in religious orders. The Grey Nuns. The Sisters of Charity.

In Ireland, likewise, nurses were born of the Church and female orders. In "Migration and Nursing in Ireland: An Internationalist History" (2009) Nicola Yeates writes, "the Catholic Church, and female orders in particular, became a key force for the development of institutional health services...This institutional domination, enabled by having secured the public trust of the wealthy and the deference of the poor...ensured 'cultural authority' and 'moral control' over their patients...The religious domination in health also gave them a high degree of influence and control over nurse training and practice" (p. 2)

The nursing profession has long been valued by our societies. The power emanating from our religious roots has been replaced mostly with the formation of professional associations and unions.

ONA came into being in 1973 for the purpose of collective bargaining for nurses by nurses. Today we stand 62,000 strong. We play a leadership role in the Canadian Federation of Nurses Unions. We are active in the International Council of Nurses (ICN) that helps set standards for health care communities and promotes social discourse about health care across the world. We exist in a greater context. We can turn to our sisters and brothers to share common concerns and best practice solutions.

Our like journeys are fraught with obstacles. Lack of respect - beyond the bedside - at management tables. Lack of access to political power. Our nurses are frustrated from lack of resources. Threats to our livelihoods. Heavy workloads. Time constraints. And importantly, lack of safety for our patients and

ourselves. Along come the moments that touch all of us directly. That kill or injure too many of us. All of us must stand against these moments of violence.

In a survey by the Emergency Nurses Association in the United States 54.5% of emergency nurses reported experiencing physical violence and/or verbal abuse from a patient and/or visitor during the previous seven calendar days (Emergency Department Violence Surveillance Study, 2011, p.16).

The research team of Cooper and Swanson (2002) drew statistics from a variety of sources that discovered health-care workers in the United Kingdom have a three to four times higher risk of violence compared to the average risk across all occupations. Approximately one-third of Swedish nurses have experienced violence at some point within their careers (p. vi).

In 2015 the Ministry of Labour for Ontario announced workplace violence in the health care sector costs the health care system about \$23.8 million CDN annually for hospitals alone. Violence claims make up 10% of the lost-time injuries in hospitals.

Methodology

In the last 15 years, ONA has learned there are four strategic areas in which to advocate.

Mobilization: Engaging the heart

Most of us want to work, to feel like we're contributing to society, to create a good standard of living for our families, to come home safely and retire healthy. That's not much to ask. In the private sector, workers are more apt to look out for themselves to ensure that happens because they know their employer is driven by profit.

In the public sector however, employers are disinclined to discuss profit. Their messages may be cloaked in positive rhetoric that masks short cuts and job cuts as recasting according to skill, rebalancing, rightsizing and finding efficiencies. Their portrayal of reality may be cleansed for public consumption. Perhaps this lulls public sector workers into a sense of complacency.

Nurses are a special breed. They care at all costs. Too often that means they accept the notion that is thrust upon them, that "violence is just part of the job." ONA has struggled to convince them to resist this attitude. We blend the messaging through every form of communication and education especially targeting Joint Health and Safety Committees struggling for a voice with difficult employers. Nurses' "right to refuse unsafe work" is very limited. A member has the right to refuse work, subject to the requirements that the circumstances are not inherent to the job or a person's life or safety is not in danger, when adequate safety protection is not available to her or him.

The Legal Arm: Advocacy in the courts

ONA's efforts against violence in the workplace escalated in 2005 with the death of member, Lori Dupont. Lori was a Registered Nurse in the recovery room at Hotel-Dieu Grace Hospital in Windsor, Ontario. On November 12, 2005, she was murdered by her former partner and colleague, an anesthesiologist at the same hospital, who died several days later from a self-inflicted drug overdose.

Lori had taken steps to end the relationship. In April 2005, she applied for a peace bond to limit their contact. In spite of ongoing indications of harassment and stalking known to colleagues and the employer, he was allowed to continue working in the same area as Lori. The first time they were scheduled to work on a weekend together with very few other staff in the area, he stabbed her to death. Dr. Peter Jaffe, an expert in domestic and workplace violence, retrospectively identified 16 risk factors in the relationship as well as numerous missed opportunities for intervention by the employer and other officials.

ONA lobbied hard for a Coroner's Inquest and won. Thankfully the jury addressed all of the systemic issues we identified. It recommended a review of the Occupational Health and Safety Act to examine the feasibility of including domestic violence, abuse and harassment as factors warranting investigation and appropriate action by the Ministry of Labour when the safety and well-being of an employee is at issue.

Two years ago, another act of violence at an Ontario Mental Health Centre threatened the life of a member. Nurse Debbie Vallentgoed survived but she was subsequently unable to work. Debbie urged the doctor

overseeing the hospital's forensic unit, to end the round-the-clock, one-on-one surveillance of a female patient, because it left nurses too vulnerable to attack, especially during the night shift. Nothing was done and on October 10, 2014 the patient repeatedly stabbed Debbie in the neck with a pen.

The Centre was charged with five violations of Ontario's Occupational Health and Safety Act and regulations in connection with the attack. A lengthy trial ensued. ONA went to the provincial labour board appealing the failure of the enforcement authority to order the employer to take precautions to protect workers. The Board ordered the employer to install a new electronic and alarm system to summon immediate assistance, provide better staff training including defending against weapons, install security cameras, hire properly trained security - 24/7 - in the forensic treatment unit, develop – in collaboration with ONA and other unions as well as the Joint Health and Safety Committee – a flagging policy and procedure to identify patients with a risk of workplace violence and implement control measures and procedures to protect workers.

The orders spelled victory for ONA and our members - but at what cost? The cost to Debbie's well-being. The cost of the court and labour board proceedings. The cost of justice delayed; the lag time during which our members were unprotected. Problems that could have been prevented.

The Public Arm: Advocacy in the media

While we are getting beat up at the bedside by patients, we are getting pummeled by our employers by a so-called skill mix change. We believe there is room in the health care system for both RNs and what we call in Ontario, RPNs or Registered Practical Nurses. (This differs from the equivalent of RPN which means Registered Psychiatric Nurse in other jurisdictions). RNs have more comprehensive education than RPNs and can autonomously care for greater complexity of client.

Both are valued, professional nursing care providers with integral skills and functions, each working within their scope of practice and in accordance with their ongoing nursing knowledge and competencies. But some decision-makers are sacrificing good sense for dollars and cents. They are re-configuring the ratio to diminish or even eliminate the RN role.

We have to be on guard. At another institution St. Joseph's Healthcare, the employer tried to cut the jobs of four registered nurses who are certified in neonatal intensive care. They called it a "test." We called it cost-cutting on the backs of the small, sick and vulnerable. We went public. And we forced the employer to put the cuts on pause.

In California in 1999, Assembly Bill 394 was born of concerns that patient safety was being compromised by inadequate staffing and fears that poor working conditions were driving nurses from the profession. The bill requires the California Department of Health Services, "with regard to general acute care hospitals, acute psychiatric hospitals, and special hospitals, adopt regulations that establish certain minimum nurse-to-patient ratios." Unlicensed persons are to be "prohibited from performing nursing functions in lieu of a registered nurse."

In Ontario we need to force the government to stop basing staffing on the bottom line. However we cannot knock them off their budget-based decision-making until the public understands "skill mix change." The public is duped into believing they can receive the same quality of healthcare with a tighter belt, when we know it means less care. Worse health outcomes. More deaths. To save a few pennies.

The Lobby Arm: The political arena at the institutional level and of government

Severe Acute Respiratory Syndrome (SARS) made its way to Toronto from Hong Kong in the spring of 2003. Our nurses struggled to care for sick patients while protecting themselves and their families. Tragically, two members, Nelia Laroza and Tecla Lin, lost their lives caring for infected patients. SARS claimed 774 people worldwide, including 44 in Canada.

ONA members demanded a public inquiry into the handling of the SARS outbreak. As a result, the government appointed Justice Archie Campbell to lead the SARS Commission of Inquiry, which considered mountains of evidence, including thousands of SARS surveys filled out by our members, before delivering a final report. His findings (2006) concluded that Ontario's hospitals were "dangerous workplaces" (p. 13) and that the province's handling of SARS was a "system failure" (p. 2). Campbell said "our public health and emergency infra-structures were in a sorry state of decay, starved for resources by governments

of all three political parties” (p. 2). He said that when workers aren’t protected, patients aren’t protected. Campbell’s report produced positive change. Under Section 21 of the Occupational Health and Safety Act (OHSA), the Ministry of Labour established an advisory committee to make recommendations to the Minister on issues and trends related to the health care industry, and develop guidance notes that can assist workplace parties. The “precautionary principle” has been included in the Health Protection and Promotion Act and in collective agreements around the province (although it hasn’t yet been put in the OHSA). The Precautionary Principle is a strategy to take reasonable efforts to reduce risk where scientific understanding is yet incomplete.

In 2015, ONA won a huge political victory at the highest levels of government! The provincial government established a Workplace Violence Prevention in Health Care Leadership Table. President Linda Haslam-Stroud was named to that prestigious table alongside the Ministers of Health and Long-Term Care, Labour and the President and CEO, of the Ontario Hospital Association.

The government recognized that “due to the nature of their work, health care workers face a number of workplace hazards including exposure to infectious diseases, ergonomic hazards, slips, trips and falls, as well as violence.” Members of this table, key stakeholders, occupational health and safety experts and patient advocates, will advise on how to reduce and prevent workplace violence for health care professionals.

What are we fighting for? Safer staffing levels. Flagging systems and tools to develop them, investigation and root cause analysis into health care regulations plus minimum criteria to guide employers to do better risk assessments. Zero tolerance signage. A provincial security standard which requires all guards to have consistent, minimum training. We are fighting for compliance. We are fighting for inspectors to ensure the Occupational Health and Safety Act is enforced to its utmost not to its minimum. This effort takes a village. We have dedicated our foremost Health and Safety experts and activists to this committee work. We have dedicated our staff to support our union leaders on the ground.

Conclusion

Engaging the heart and mobilizing. The legal arm. The public arm. The lobbying arm at institutional levels and at the highest levels of government. These are our four key strategic areas of focus. At the core, advocacy begins at the bedside. With the nurses who know about the frontline. With the nurses who are passionate advocates for their clients. Nurses know when they are unsafe, their patients are unsafe.

In a thesis on nurses and political advocacy, Crystal Avolio reflects “at the core of the nursing profession are values, beliefs and practices that align nurses well in the political arena as change agents for health policy... Nurses possess the skills required to analyze, think critically and decipher health policy information” (2014, p. 14). May nurses apply these skills to leverage our power in loud voices. May we play large. As author Marianne Williamson once wrote:

Your playing small does not serve the world. There is nothing enlightened about shrinking so that other people won't feel insecure around you. We are all meant to shine, as children do...It's not just in some of us; it's in everyone.

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Learning objectives

Participants will...

1. share knowledge about methodologies to address systemic violence.
2. be inspired to a “call of action” to engage the nurses profession worldwide to recognize and report workplace violence.

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Health care providers perceptions of violence in children and women

Sub-theme: Policy/guidance on best practice initiatives

Paper

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Keywords: Violence, aggression, pediatrics, maternity, women, children, perceptions

Introduction

Many agencies or governing bodies support a black and white discernment of aggression, or violence, within their policy definitions without articulation of a continuum of escalation. The Worker's Compensation Board of British Columbia (WCB) refers to 'violence' within their documents and policies defined as "the attempted or actual exercise by a person, other than a worker, or any physical force so as to cause injury to a worker," including "any threatening statement or behaviour which gives a worker reasonable cause to believe that he or she is at risk of injury" (WCB, 2005). Intent to injure, is not considered in the definition of 'violence' (WCB, 2005). A report recently released by the WCB, explored nurses' experience of workplace violence, and did not include the term aggression. The extent of the definition of violence in this document spans verbal harassment, sexual assault and bullying amongst other variables (Henderson, 2010). A study by Dean, Gibbon, McDermott, Davidson, & Scott, 2010, is one of the only studies to investigate the perceptions of aggression within a pediatric mental health care environment. The study was part of a "quality improvement activity" and was a piece of a larger project documenting aggression and its sequelae in this service (Dean *et al.*, 2010, p. 18). "Aggressive behaviour rarely takes place in a vacuum....Intolerable environments, ineffectual interactions are far more likely to influence the behaviours than symptomatology alone" (Irwin, 2006, p. 315). Foster, Bowers & Nijman state aggression "can be expressed in many forms, ranging from a patient raising their voice during an argument to an unprovoked violent attack involving a weapon" (2007, p. 141). The variation in definitions articulated throughout the literature, creates confusion for health care providers understanding of the terms 'violence' or 'aggression'.

To ensure a safe work place for all healthcare staff, clients, and visitors, the province has implemented an alert system which incorporates processes for identifying and caring for potentially violent clients. With that goal in mind, the system was created to provide a systematic process which alerts employees to a potentially violent client, as per Workers Compensation Act Part 4, Sec 29(a), (b) and Part 4 Sec 30(1),(2).

The current study

The aim of this study was to assess health care providers' understanding and perceptions of 'violence' and determine which precipitants health care providers use to apply the alert system to a patient or visitor. As well, to assess health care providers' understanding how the alert system should be applied, including who would receive the alert, how they think the alert will affect the outcome of patient care and how general safety will be affected. The results could be used to inform future education and policy development for the agency. The first phase of the study involved participants from various pediatric medical, mental health and maternity units. The investigators used an adapted version of the Management of Aggression and Violence Attitude Scale (Duxbury, 2006), the MAVAS-Likert (abbreviated to MAVAS-L). The original MAVAS has been used in the United Kingdom to assess the views of mental health nurses and psychiatric in-patients as to the causes and management of patient aggression and violence (Duxbury 2002, Duxbury & Whittington 2005; Duxbury, Hahn, Needham & Pulsford 2008). The MAVIS-L, which replaces the original visual analog scale with a 5-point Likert scale (5 = Strongly agree, 1 = Strongly disagree), has been used to study staff attitudes towards violence in a high-security clinical setting (Pulsford *et al.*, 2013).

The second phase of the study, (still in process) involves conducting focus groups with health care providers from the clinical units targeted in the survey portion of the study. The focus groups explore health care providers understanding of the ways in which the alert system should be applied within providers own clinical context.

Method

Population

The population of interest included all health care providers working within the provincial pediatric and maternity tertiary centers. Initially our intent was to compare one unit from each hospital that typically experiences a relatively high level of violence (as identified through the provincial reporting system), with a second unit within the comparative hospital due to the perceived lower experiences of violence.

Phase 1 - Survey

Method

Recruitment

Participants were recruited through an email sent via the Program Managers for each of the targeted clinical units. The Research Coordinator distributed an email with a link to the online survey to each of the Program Managers for the identified units, who then distributed the email to their unit staff.

Consent

The introduction to the survey (both the online and hard copy versions) included a modified consent form, which provided all the information contained in a typical behavioural consent form, but without the signature page. Instead, at the end of the modified consent form, the following statement appeared: "Completion of the following survey indicates that you are willing to be involved in this study". This method of consent allowed eligible participants to receive the information contained in a standard consent form, so that they were able to decide whether they would participate (by filling out the survey) or not. Health care providers were able to fill out the survey immediately after reading the consent statement. However, they could also return to the survey (via the link provided in the email) at a later time and complete the survey at their leisure.

Instrument

The Management of Aggression and Violence Attitudes Scale (MAVAS) is a valid and reliable tool for measuring health professionals and consumers attitudes towards aggression and its management. Previous work under-taken to validate the MAVAS found that it demonstrates satisfactory content and construct validity (Duxbury, 2006). The MAVAS contains 13 statements about causes of aggression and violence, reflecting internal, external and situational/interactional models of aggression, and 14 statements relating to different approaches to aggression management. Participants using the MAVAS give their views on each statement on a visual analogue scale. An adapted version of the MAVAS (the MAVAS-Likert or 'MAVAS-L') replaces the visual analogue scale used in the original survey with a 5-point Likert scale (5 = Strongly agree; 1 = Strongly disagree). Studies have demonstrated that the Likert scale format is more straightforward for participants to complete (Flynn *et al.* 2004). In addition to the questions included in the original MAVAS, the MAVAS-L includes three questions which aim to capture particular concerns within a high security hospital setting. In these three additional questions, participants are asked to rate their agreement (or disagreement) with the statements, 'Patients from particular ethnic minority groups are more likely to become aggressive', 'Differences in cultural beliefs between patients and staff may lead to aggression' and 'Having both male and female staff on a shift is important in the management of aggression'.

Analysis

The categorical data gathered from the surveys completed by staff members from the participating clinical units are described using descriptive statistics. Comparisons will be made between each of the clinical areas. In addition, the units will be categorized into those units that experience a comparatively low level of violence and those units that experience a comparatively high level of violence, with three units in each 'violence level' category. Comparisons will be made between low and high violence units. Chi squared tests will be used to compare the groups on categorical variables (i.e., the Likert-scale questions in the survey). Below are the initial findings to date and more fulsome report will be available for the conference presentation.

Findings

Demographic data N = 100	n [%]
Gender	
Female	92 [93%]
Male	Not available
Age (years)	
21-25	2 [2%]
26-30	24 [25%]
31-35	33 [34%]
36-40	13 [13%]
41-45	6 [6%]
46-50	7 [7%]
51-55	7 [7%]
>55	5 [5%]
Agency	
Pediatrics (includes Rehab)	29 [5%] 4 [4%]
Maternity	21 [23%]
Pediatric Mental Health (includes adult)	35 [%]
Unreported	tbd
Role	
Allied Health Professional	12 [12%]
Nurse	80 [81%]
Physician	1 [1%]
Other	6 [6%]
Location	
Inpatient	72 [73%]
Outpatient	4 [4%]
Both	22 [22%]

The preliminary results of the MAVAS-L are described below.

- **Internal Causative Factors:** Participants perceive that there is a particular group of patients that tend to be more aggression than others. The majority of participants perceive that patients will not calm down if left along. Equally half of the participants feel that patients should have control over their aggressive behaviors.
- **External Causative Factors:** A large majority of participants indicated that patients are aggressive because of the environment they are in. A very large majority (93%) of participants perceived that restrictive environments can contribute toward aggression.
- **Situational/interactional causative factors:** A large majority (66%) indicated that others make patients aggressive. Most participants identified that poor communication between staff and patients leads to patient aggression. They also perceived that improved one to one relationships between staff and patients could reduce the incidence of aggression. A very large majority of participants perceived that cultural beliefs and particular ethnic groups are more likely to lead to aggressive behavior.

91% of participants identified that different management strategies are used Most participants indicated that more could be done to effectively manage aggression on the units. A majority of participants indicate that medication should be used more frequently. Interestingly, a large majority of participants also indicated that medication can sometimes lead to aggression.

Seclusion is perceived to be used more than necessary. Participants indicated that restraint is used for the patient's own safety. However a majority identified it was used more than necessary. Non-physical methods

could be utilized more. Alternative to medications and containment could be used more frequently and that de-escalation is overtly more effectively in preventing violence.

A more detailed analysis will be available at the conference.

Phase 2: Focus Group component

After completion of the survey component, focus groups will be conducted with participants from the same clinical units that were asked to complete the survey. The aim of these focus groups is to further explore staff's experiences with, and understanding of, violence within their particular clinical units. The focus groups will allow for more in-depth qualitative exploration of perceptions of violence within health care provider groups, who are exposed to similar clients and families.

Analysis plan

Each focus group discussion will be audio-taped, transcribed, and enhanced with the data documented by a designated note taker. An overall report will be produced summarizing the focus groups, highlighting common themes and differences noted among participants.

Limitations

The survey used has to the investigators knowledge been used within a pediatric/maternity agency. Participants varied in experience, area of work and age. There were few male or non-nursing staff participants in the study. Future research would include more non-nursing staff and validation of the Likert version of the MAVAS.

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Learning objectives

Participants will...

1. identify factors that influence health care providers' decisions regarding aggressive patients.
2. be aware of health care providers' perceptions of when to implement an alert system.
3. appreciate the complications in implementing a single violence alert system and process for multiple contexts.

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Burnout and Disruptive Behavior: From Theory to Practice

Sub-theme: Policy/guidance on best practice initiatives

Workshop

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Keywords: Burnout, workplace violence, disruptive behavior in healthcare, micro violence, micro trauma, extraneous cognitive load, perception of threat

Abstract

Disruptive behavior is a form of workplace violence in healthcare which has been the subject of The Joint Commission sentinel event alert entitled “Behaviors that undermine a culture of safety”- Intimidating and disruptive behaviors interfere with safe patient care communication among staff and has been associated with burnout and other staff, intention to leave, and staff turnover. Errors and malpractice claims have been associated with disruptive behavior as well.

There are a spectrum of contributing factors to disruptive behavior. Some healthcare professionals can be mistakenly labeled as disruptive when taking issue with unsafe or inefficient work environments which can affect the healing environment for patients. The other end of the spectrum can occur when some individuals are chronically and persistently intimidating and abusive to others. There are also various gradations and combinations along this spectrum.

It has become more clear over time that many cases of disruptive behavior may have burnout as a upstream contributing factor. Hicks and *et al.* at published work on interventions for improving professional behavior with graded steps depending on the number and seriousness of offenses. Taking a broader approach, interventions for reducing disruptive behavior may be more effective if they are inclusive of initiatives for reducing burnout. This approach will send a message of caring and support to healthcare workers while still having expectations of professional conduct.

The healthcare environment has increased in complexity and demands with extensive expectations on healthcare professionals now more than ever. Healthcare reform in the United States has drastically increased regulations from numerous authoritative sources that unfortunately have not harmonized their expectations nor significantly collaborated in the process. A recent study in physicians show that over the period of time from 2011-2014 prevalence of high level burnout went from 46% of physicians nationally to 54% and quality of life went down over that same period of time. . During this same period of time the general population prevalence of burnout went down in their quality of life when up. Burnout can be conceived as the result of numerous cumulative micro-traumas. The micro aggressions causing the micro traumas are many described in Privitera, Bowie and Bowen 2015, such as disrespect, deprivation of human needs, belittlement, and bullying, various forms of micro insults, micro invalidations that have been common in healthcare worker’s environment. Systemic /organizational factors are at play, such as multiple uncoordinated mandates and regulations that in sum total are either impossible to achieve or come at personal cost.

Disruptive behavior in physicians has been estimated to be 2-4% of the physician population. Disruptive behavior is a low frequency by high impact event, but burnout is experienced by individuals, the healthcare system and effects on patient quality of care on a daily basis. Wellness initiatives have been shown to increase patient satisfaction, have been more recently interpreted as a quality indicator of the particular healthcare system.

We will described the process of wellness initiatives at University of Rochester Medical Center, the journey involved, the theories applied, and the considerable challenges in overcoming individual, institutional, and socio-political barriers to the concept of being concerned about the welfare and wellness of healthcare workers. The Triple Aim has been a guiding principal in healthcare reform, as proposed by Donald Berwick et al, The Triple Aim consists of improving quality of care, patient experience, and reducing healthcare costs. Unfortunately, it appears that leaving those that are attempting to provide good healthcare off this mantra of

healthcare reform has contributed to overlooking the problems the healthcare workforce has in logistically sustaining practice of care. We need to be aware of this dilemma when trying to determine if it is an individual or organizational/ environment of care problem. Burnout has been associated with higher number of errors, malpractice claims, workplace violence, disruptive behaviors, incivility, leaving medicine, retiring early, and multiple other impact issues to be described.

All these rapid, uncoordinated organizational changes In the setting of the “hidden curriculum’ ‘of medical and nursing training, with patient always first, buck up, suppress how you feel and keep going, it has left the situation ripe for increasing amounts of professional burnout. It has been proposed that The Quadruple Aim be substituted for The Triple Aim mantra to include improving the experience of doctors, nurses and others providing care for patients as the fourth aim augmentation to Berwick’s Triple Aim. The advantages of the Quadruple Aim help with overall advancement of wellness, morale and engagement of healthcare workers in the care of patients.

Learning objectives.

Participants will...

1. be able to recite major components of professional burnout and how this affects engagement.
2. understand how ‘the quadruple in his HD philosophical tenant in improving wellness and improved patient care.
3. recite major barriers to cultural change of an institution to achieve a culture of caring, culture of respect, and culture of safety.

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Agent of Change: A Push for Legislation to Protect the Healthcare Provider

Sub-theme: Policy/guidance on best practice initiatives

Paper

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Keywords: Advocacy, legal, nursing, lateral violence

Background

Lateral violence is defined as a set of destructive behaviors occurring between colleagues intended to humiliate, offend, or cause distress. It has been noted The Mother of Modern Nursing, Florence Nightingale's intimidating, domineering, and caustic manner towards nurses of lower social class during the Crimean War planted the seeds for lateral violence to take root in present - day nursing culture. Nightingale's sarcastic nature throughout her 1859 book "Notes in Nursing" set the tone for the prevailing incivility between nurses.

Context

Worldwide, many healthcare organizations have attempted to abolish this problem of lateral violence with various strategies such as education or organizational leadership. However, based upon the sheer volume of articles published in reference to lateral violence, these methods are not solving this dilemma. The financial and psychosocial consequences of lateral violence on the nursing profession are heinous. Thousands of nurses leave the profession each year due to unwarranted abuse. Accountability must be restored throughout the nursing profession. Within the United States, an organization, "Workplace Bullying Institute" has been invaluable with their innumerable attempts to advocate for legislative protection from an abusive work environment.

Methodology

Secondary data will be reviewed initially through Chamberlain College of Nursing's library using a range of information sources such as EBSCOhost, ProQuest, academic and commercial abstracts, bibliographic databases, and internet search engines. To aid the search, a table of key terms will be constructed and the sources located will be correlated with this.

Findings and Implications

Most United States legislators consider lateral violence an organizational problem instead of an issue of which should be addressed legislatively. Expanding current anti-bullying statutes to include healthcare providers.

Learning objectives

Participants will...

1. be able to articulate the necessity of anti - bullying law expansion.
2. analyze examples of contemporary policy as it relates the protection of the healthcare provider.
3. examine current anti - bullying statutes from the United States and Internationally.

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Educational and managerial policy making to reduce workplace violence against nurses and their fear: An action research study in Iran

Sub-theme: Policy/guidance on best practice initiatives

Paper

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Keywords: Workplace violence, Fear of violence, Workplace violence prevention program, action research

Background

Violence in the emergency department is serious concern for the permanent staff. The organization's violence prevention program (WVPP) requires strong commitment and a clear policy for occupational safety personnel. One of the most important factors in creating a successful program is ensuring that the program meets the unique needs of the organization.

Method

This project involved the implementation of change, therefore the selection of an action research design seemed appropriate. The focus group process of data collection was used during the diagnosing, planning act, acting and evaluation phases. Data were continuously gathered during a 10 month period from December 2013 to May 2014. Nineteen persons participated in four focus groups. The first phase of this research aimed to determine the level of patients and their family violence against nurses. The second and the third phase of this research, including designing and implementation of a workplace violence prevention program and which included a combination of educational and managerial intervention.

Results

It was evident that all participants were concerned about violence in the emergency department and perceived the problem as increasing. Thematic analysis results supported the relevance, feasibility, and saliency of the planned intervention strategies. With the exception of a few items, employees and managers from the different occupational groups agreed on the interventions needed to prevent and manage violence against ED workers.

Implication for practice

The results and discussions during the focus groups with ED managers and employees supported the data showing that violence in the emergency department is increasing, and that interventions are needed to reduce the workplace violence. We used a participatory action research design to explore the implementation of workplace violence prevention program. The advantage we experienced is that we were able to adapt the implementation of WVPP to the setting and to tailor the implementation strategies. In this way, we empowered nurses to play the role of violence preventive Nurse. It was the nurses themselves who proposed using the WVPP. The data also showed that the planned intervention strategies could reduce the frequency of violence against nurses and their fear.

Learning objectives

Participants will...

1. have a basic understanding of a work place violence prevention program that could be used in emergency department.
2. learn of strategies for reducing the frequency of violence against nurses and their fear.

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United States Workplace Violence Policy and Regulatory Initiatives under the Obama Administration

Sub-theme: Policy/guidance on best practice initiatives

Poster

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Keywords: Federal government, policy, regulations, state laws, citations

Background and context

Workplace Violence (WV) continues to be a major hazard facing U.S. healthcare workers. Historically there has been minimal policy and regulatory actions to address the problem. However, over the eight years of the Obama Administration, the federal government is finally beginning to address the problem via a number of important policy and regulatory initiatives. Over this same time period, a number of individual U.S. states have passed laws and regulations mandating workplace violence prevention programs.

Methodology

This poster presentation will summarize and discuss the implication of the following federal-level initiatives: Federal U.S. Occupational Safety and Health Administration's (OSHA) revised WV Prevention Guidelines, Enforcement Guidelines, OSHA 5(a)(1) "General Duty Clause" inspections and citations, the Government Accounting Office (GAO) study and report, and the recent petition for a federal WV standard by a coalition of labor unions, as well as recent State WV laws and regulations. The presentation will then focus on the Federal OSHA regulatory actions, specifically, the General Duty Clause citations.

Findings

OSHA increased its yearly workplace violence inspections of health care employers from 11 in 2010 to 86 in 2014. The increase is attributed in part, to a rise in employee complaints and programmed inspections following implementation of a 2012 3-year National Emphasis Program (NEP) targeting nursing and residential care facilities and included WV as one of the hazards. To date however, OSHA issued 5(a) (1) citations in only about 5 percent of these inspections, in part because of the challenge of developing support to address the criteria for these citations. The 2016 GAO Report, acknowledged that the (OSHA) increased its education and enforcement efforts to help employers address workplace violence in health care facilities, but identified three areas for improvement in accordance with federal internal control standards. First, provide inspectors additional information on developing citations; secondly, follow up on hazard alert letters; and finally, assess the results of its efforts to determine whether additional action, such as development of a standard, may be needed.

Implications

The implication of these actions and initiatives for U.S. employers, workers and unions will be discussed. Translation of work to other geographical contexts will be addressed. Following this presentation, participants will be able to:

Learning objectives

Participants will...

1. be able to describe U.S. regulatory mechanisms to prevent workplace violence in the health care workplace.
2. identify strategic policy initiatives that will advance workplace violence prevention in their geographical and political context.

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Important Safety Strategies for Providers offering Home based Behavioral and other Healthcare Services

Sub-theme: Quality safety and risk reduction initiatives

Workshop

*Deborah Jones
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Keywords: Worker Safety Tips and organizational Risk Reduction, Strategies for in home service visits

Background & Context

The point of service for the health care sector has become increasing home based. Funders and policy makers are purposefully driving the point of service away from hospitals and clinics to the homes of the patients; this trend is particularly prevalent in the mental health field. As this direction expands, the risk posed to mental health practitioners providing these services have concomitantly increased both from the patients being treated and the environments many of persons with mental illness reside. As a result, a safety conscious worker and the need for comprehensive worker training and safety strategies by organizations is extremely important to manage the risk and provide quality services.

Methodology

The presenter will offer a 90 minute workshop. The Workshop has been developed from her 35 years' experience as an individual in home provider, leader in government and over the past 27 years as the CEO of a company that provides extensive array home-based behavioral health, general care management and hands on nursing care services.

Content

The presenter will offer an overview of the problem and briefly describe the risk issues involved in providing in home mental health services particularly to those patients who are generally reluctant to seek services on their own.

Implications

The presenter will describe that exposure to violence is a common place experience in many of the urban and suburban areas given the low socio-economic areas most of the patients reside, how exposure to the threat of violence and crime is common place and violence is prevalent both for practitioners and patient stand point. The presenter will describe that risk for practitioners is further exacerbated due to the fact, they face unstable and unpredictable patients and or roommates alone. Therefore, providers and healthcare leaders will need to have comprehensive strategies to manage the risk to practitioners providing in home mental health intervention. The presentation will include individual practitioner field based safety tips and a discussion of the overall need for risk management strategies for healthcare leaders and what elements these may include.

Workshop Structure

The Presentation, in English, will include a presentation of material using a didactic method augmented with the use of a PowerPoint presentation for 45 minutes, interactive discussion of the topics presented for 15 minutes, opportunity for information sharing on the various topics for 15 minutes and will offer a 15 minute question and answer period.

Learning objectives

Participants will...

1. gain a basic understanding of the possible risks faced by practitioners providing in home behavioral health supports.
2. gain an overview of field safety strategies a worker will need to employ when conducting a home visit.
gain a basic understanding of the basic elements of a risk management strategy health leaders and executives will need to employ.

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Identifying patients at risk of inpatient aggression at the time of admission to acute mental health care – What factors should clinicians consider?

Sub-theme: Quality safety and risk reduction initiatives

Paper

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Keywords: aggression, acute care, assessment, risk factors.

Abstract

The aim of this study was to identify, at the time of admission, predictors of aggression in adults admitted to acute mental health care. Adult patients (n=350) consecutively admitted to the National Institute of Mental Health (NIMH) in Sri Lanka were assessed for a wide range of dispositional, historical, contextual and clinical factors associated with inpatient violence. Clinical factors were assessed using the Brief Psychiatric Rating Scale and risk of aggression using the Brøset Violence Checklist. All 350 patients were followed for 72 hours following admission and observed for aggression using the Overt Aggression Scale. Fifty-nine patients (16.8%) met criteria for aggression. Members of the aggressive group were more likely to be single, less than 35 years old, and have caused harm to others or damage to property in the 2 weeks prior to admission. Multivariate analyses pointed to a decreased risk of aggression in depressed and withdrawn patients. Controlling for other variables, an elevated total score on the Brøset Violence Checklist made a unique statistically significant contribution to the prediction of violence following admission. The antecedents to aggressive behaviour were similar to those found in developed countries suggesting cross-cultural similarities in aggressive behaviour. A history of violence prior to admission and an elevated score on the Brøset Violence Checklist emerged as significant predictors of violence following admission.

The study is somewhat unique in that it considered patient / environmental factors in addition to risk assessment measures. Most previous studies have reported on patient / environmental factors or risk assessment tools but not both.

Learning objectives

Participants will...

1. learn about the dispositional, historical, contextual and clinical factors most strongly associated with violence following admission to inpatient care.
2. learn about the added benefit of using an assessment tool at the time of admission.

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The role of medical ethic, medical law and medical discipline in Patient care abuse

Sub-theme: Professional, legal and ethical impacts of aggression/violence

Workshop

Siti Pariani Mother

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Keywords: Patient care abuse, medical ethic, medical law, medical discipline

Abstract

Patient care abuse or neglect is any action or failure to act which causes unreasonable suffering, misery or harm to the patient. It includes physically striking or sexually assaulting a patient. It also includes withholding of necessary food, physical care, and medical attention. It can occur in settings such as hospitals, nursing homes, clinics and home visits.

Discipline is domain of knowledge, instruction or learning of the sciences. Medical is relating to the treatment of diseases and injuries. Then, the medical discipline is the knowledge, instruction or learning the treatment of diseases and injuries.

The Medical ethics is a system of moral principles that apply values and judgments to the practice of medicine. Ethic is moral principles that govern a person's behavior or the conducting of an activity. The basic concepts and fundamental principles of decent human conduct. It includes study of universal values such as the essential equality of all men and women, human or natural rights, obedience to the law of land, concern for health and safety and, increasingly, also for the natural environment.

The Medical law is the body of laws concerning the rights and responsibilities of medical professionals and their patients. The main areas of focus for medical law include confidentiality, negligence and other torts related to medical treatment (especially medical malpractice), and criminal law and ethics

The Medical professional should concern in the patient safety. However because the medical doctor should comply the medical ethic, medical law and medical discipline, with one will be comply first ? Every cases have their own attention. Some cases require the first is medical ethic, another need medical law the others claim medical discipline . Who, when, where, how the decision making process in the patient care abuse?

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Nurses' perceptions of transgressive behaviour in care relationships: A qualitative study

Sub-theme: Policy/guidance on best practice initiatives

Paper

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Keywords: Aggression, care relationship, general hospital, nurse-patient relationship, nurses, nursing, qualitative research, transgressive behaviour, violence

Background & context

Patient aggression towards healthcare providers occurs frequently. Nurses in particular are at risk of encountering aggressive or transgressive behaviour due to the nature, duration and intensity of relationships with patients. This study analysed nurse perspectives and aimed to acquire insight into the onset and meaning of transgressive patient behaviour in a general hospital setting.

Methodology

Qualitative research according to the grounded theory method was conducted. Data were collected in 2011 through individual interviews with 18 nurses who were selected using purposive and theoretical sampling.

Findings

Findings revealed that various nurse-patient interactions can result in episodes of transgressive behaviour, depending on the interplay of determining and regulating factors which have been identified at the patient, nurse and ward level. Experiences of transgressive behaviour are influenced by degree of control nurses experience over the provision of care; the degree of patient acceptance of organizational and ward rules, the degree of gratitude and recognition expressed by the patient and the extent of patient regard for the nurse as a person. Factors affecting transgressive experiences were a trusting relationship between patient and nurse; the extent to which patient perspectives are understood; methods of managing transgressive behaviour; and the influence of the team, head nurse and ward culture and habits.

Implications

The results of this study can support the development of nurses' coping ability and self-confidence to mitigate or prevent experiences of transgressive behaviour.

Learning objectives

Participants will...

1. have an understanding of how perceptions of transgressive behaviour occur and what mechanisms impinge or influence own experiences of transgressive behaviour.
2. learn factors influencing perceptions of transgressive behaviour on the patient, nurse and ward level, and become aware of how these factors entail dynamics in maintaining, reinforcing, or decreasing perceptions of transgressive behaviour.

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Chapter 8 – Other themes on violence in the Health Sector

This chapter encompasses presentations on the following sub-theme of the conference:

- Other subtheme, but related to the main theme of the conference
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Between Individualism and Collectivism: Arab social workers dealing with violence dilemma in Israel

Other subtheme, but related to the main theme of the conference

Workshop

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Keywords: Minority, Arab minority, Violence, Dilemma

Abstract

The issue of the medical ethics in a multi-cultural society draws a great deal of attention by many professionals, from the medical field and from other helping professionals as well (social workers, psychologists, etc.). The state of Israel is a multi-cultural society, and its dominant cultural orientation is individualist. However, within this society there are additional cultures characterized by collective values, one such group is the Arab subgroup that represents 20% of the total population in Israel. Arab social workers in Israel experience numerous societal and medical dilemmas, often between their professional ethical code (that represents individualist values), and their cultural values (that often represents collective values). In the following article, I shall illustrate the aforementioned dilemma through a case story of a violent conduct of a mother towards her daughter. The analysis of this case illustrates: (a) a conflict between opposing values; (b) the practical translation of these values. The author applies a 3-steps model to addressing these ethical dilemmas in the medical context. This model is especially relevant in a case of 'culture within culture', as I will illustrate in the following sections.

Introduction

The Arab Society in Israel

The Arab society constitutes about 20% of the total population in the state of Israel, and is comprised of three main religions: Muslims, Christians and Druze. The dominant orientation in the Arab society (regardless of the religion) is collectivist, and individuals in it tend to identify themselves through their family and their community (Al-Krenawi & Graham, 2000; Haj-Yahia & Sadan, 2008). However, in Israel - they are widely exposed to the individualist Jewish-Israeli culture, which clashes with their collectivist culture. One can even distinguish between the individualist values on the one hand, and the collectivist values on the other, on family issues. As such, the parents of the Jewish majority subgroup tend to emphasize their children's individual autonomy, relative distinctiveness from society (Triandis, 2001) and to depend on mainly themselves and not on others (Triandis, 1990, 1995; Triandis, Brislin & Hui, 1988). However, parents in the Arab minority subgroup tend to teach their children to rely on collective values, such as conformity, mutual assistance, and reliance on others, especially the elderly. These values direct parent-child communication styles, especially in occasions of indiscipline of their children.

Parent-Child Communication in the Arab Society

Studies show that culture has a broad influence on parenting styles and on parent-child relationships, since parents tend to raise their children in accordance with the values of the culture in which they are living (Dwairy & Achoui, 2006). Scholars showed that living within a collectivist subgroup greatly affects all domains of life, including child-bearing and child-raising (Haj-Yahia & Sadan, 2008; Buchbinder & Jammal-Abboud, 2012), significantly more than individualist groups.

Recent years has shown that the Arab society is a society in transition. This phenomenon is relevant for various aspects, among them - family life. However, despite these changes and transitions, the most common parent-child communication style is still the patriarchal one, which maintains the values of collective belonging and its derived set of norms. One main application of this style is the tendency to punish undisciplined children, including battering and other physical punishments. This style of parenting is reinforced by the collective, in order to preserve the traditional cultural values.

Arab Social Workers

Arab social workers experience various societal and medical dilemmas, often between their professional ethical code (that represents individualist values), and their cultural values (that often represents collective values). As a result, Arab social workers find themselves in an ongoing conflict, that they are expected to resolve on their own.

In the absence of a formulated model for their professional work, social workers' conflicts can be resolved in two different (and conflicting) directions: either toward the values of their profession that symbolize a preference of individualistic values or toward their society that symbolize a preference of their traditional social values. Both of these alternatives carry with it the potential for a personal and professional frustration.

The aim of the current article is to develop a practice wisdom, which could enable Arab social workers to integrate between seemingly conflicting courses of action, and not to disregard important values (either professional or social), since it could cause negative outcomes among their clients. The main goal, therefore, is to be both professionally ethical and effective therapists.

The 'Culture within Culture' Paradigm

The 'Culture within Culture' paradigm is one form of a cross-cultural encounter. Israel is a good example of a multicultural society, since it is divided at various aspects, such as nationality, ethnicity and religion (Al-Haj, 2003; Jaffe, 1995; Nadan & Ben-Ari, 2014).

Studies show that one of the major cross-cultural encounters in Israel is between the Jewish majority and the Arab minority (Grodofsky-Moshe & Yudelevich, 2012; Jammal-Abboud, 2013; Nadan & Ben-Ari, 2014), and this encounter occur in various venues, including economic, social, national, and so on. We will focus on the clash of cultures in the venue of psychosocial therapy, as a part of the Israeli government-directed welfare system.

Case Story: The 'Beyachad Center' in Shefaram

The 'Beyachad Center' for parents and children in Shefaram is a therapeutic center that provides a community-level response for children at risk and their parents. The center aids children aged 5 to 12 and their parents, in families where a deficient parenting causes abnormal development among children. The main intervention principles include emphasis on a holistic perception of the children's and families' needs. Each family is offered a unique, tailored program according to its needs, including individual and group interventions, and the family is involved in designing the therapeutic program and in evaluating changes and improvements. Using a culturally-sensitive approach, the work at the center is based on gaining the families' trust first, through emphasis on accepting traditional roles. The therapists at the center operate with the aim of providing an appropriate therapeutic service for all families, through raising their awareness to general cultural values in relation to parenting and in relation to potential conflicts between the collectivist culture and the Western cultural values that tend to guide social workers. This will be illustrated in the current article through the case of an Arab mother that battered her daughter and was referred to the center for assistance.

Case Description

Rawan (alias) is a widowed mother of three children, aged 10, 9 and 4. Rawan lost her husband after he suffered a sudden industrial accident a year ago. The family is known to the social services for several years now, since they went through economic hardships in the last couple of years. Three months ago, the social workers from the social services department referred Rawan to the 'Beyachad Center', since she described difficulties in communication with their children, after the sudden loss of her husband. She also reported that there is a large unwanted interference by the extended family (grandfathers and uncles) in familial issues, and in educating the children. After getting the reports from the social workers of the social services department, I contacted a neurologist and the head of the unit of children's development in the HMO (Health Maintenance Organization), and heard of several occasions in which Rawan battered her daughter, and even left marks on her neck.

The Dilemma

The dilemma derives from the fact that myself and the physician are Arab, and we know the Arab society and its attitude toward widowed or divorced women. We know that every legal action by the mother could jeopardize her and her children. We also know that these costs derive from the patriarchal values, according to it - women should obey and adhere men, and women should focus on child-raising. We also knew the tendency of other community members to gossip on widowed and divorced women, and that the gossip usually comes with a negative labelling. In other cases that myself and the physician had to interfere, we knew that we should honor the basic values of the Arab culture, and to enable the extended family to take part in the intervention program in order to maintain family unity. We also acknowledged the importance of the social sanctions value, that serves as a way to teach family members what is right and what is wrong.

But, besides the cultural values – we know that there are other values that are manifested in state laws. One such example is child protection law, according to it – social workers and physicians are obliged to report to the police in case they identified child maltreatment. As such, the professional socialization of social workers and physicians is bound to individualist values regarding children's position in front of their parents.

The decision to act exactly according to the law could endanger the trust relationships between professionals and the family, and so – Rawan and her entire family could potentially dropout of the therapy. The dropout could further isolate her and her family from the community. However, avoiding the report to the police is a criminal and ethical misconduct, and could lead to further violence and maltreatment of the children in the family. In this case, we – as professionals – are somewhat trapped in the situation, as we want to maintain the therapeutic relationship, but have to adhere the legal obligations. In order to find a solution to this ethical dilemma, I developed a 3-level model for the medical context: (1) Learning the matrix attributes; (2) Translating the situation twice: one time according to the societal context and the second time according to the professional context; (3) Building a societal-medical bridge between these two contexts (individualism vs. collectivism). The prime consideration will always be the clients and their best interests.

The Intervention Model

Phase 1: Learning the Matrix Attributes

This phase includes a comprehensive assessment, by questioning these questions: (a) What is the essence and importance of the extended family, and where does it stand in the continuum between collectivism and individualism? (b) What are the mother's strengths to handle the current situation? (c) What is the quality of relationships between the mother and the extended family? (d) Was the battering incident a random occasion, or is it related to previous occasions? (e) How willing is the mother to make the change in the current situation? Through this assessment, I could identify the strengths that will help the mother to build the bridge to change, instead of freezing and maintaining the previous problematic situation. I also use this assessment in order to gain awareness of my own values and of my professional values that could potentially harm the client.

Phase 2: Translating the Situation Twice

In this phase, we will have to translate the situation twice: One time, according to the societal context and the second time according to the professional context. In the case of Rawan, we see that she tend to use violence to educate her children. In a certain level, that violence could be interpreted as her breaking the law. However, in the family therapy, Rawan was committed to the intervention program, but did not discuss her tendency to use violence as a means to discipline her children. Furthermore, in the assessment, we considered the pressures that derived from the loss of her husband, the stress that she experienced, and the criticism she experienced from the extended family. These pressures could have led to the violence that she conducted towards her daughter. Besides the familial pressures, we should also consider the social-cultural pressures.

Rawan felt that her community treats her as a labelled person, and there were gossips and negative attitudes towards her. She was afraid that her community will further label her, if they will discover that she is attending parents' guidance or family therapy.

Phase 3: Building a societal-medical bridge between the two contexts

The assessment of the current situation will lead to the building a bridge between the two contexts: individualism on the one hand, and collectivism on the other. Building the bridge could maximize the intervention outcomes, and to fit the right solution for the current needs. In the case of Rawan, I invited her to assess the situation in joint efforts. We discussed the options and consequences of each course of action. I clarified the legal dilemma, and tried to raise her awareness in order to work together in a trusting relationship. I explained to her my obligation to report the violent conduct, along with the required cultural sensitivity. After our conversation, we held a multi-discipline committee, that included Rawan, her daughter's pediatrician, a representative from the Beyachad Center (myself), the case manager from the social services department, and the social worker that in charge of implementing the Youth Act in our local council.

In this committee, the pediatrician described the daughter's situation and his acquaintance with family. I presented the situation's analysis in the therapeutic center, and my colleagues from the social services department illustrated the legal aspect. Rawan expressed her regret on the violence that she had conducted, and said that she is willing to precede the therapeutic process at the center. The committee decided to fund the family therapy, in order to allow Rawan to keep coming to the center.

In conclusion, the bridge comprised of a mixture of individualist-professional values (mainly, from the social services), along with collectivist-cultural values (mainly, accommodating the intervention program to the values of the client's values).

Learning objectives

Participants will...

1. have an understanding about Arab social workers dealing with violence dilemma in Isreal.
2. identify the meaning of 'culture within culture'.
3. have a sensitive culture model for solving such delimas in a situations of 'culture within culture'.

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Snakes in the Nursing Station: Discourses of Workplace Bullying in the Nursing Profession

Other subtheme, but related to the main theme of the conference

Paper

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Keywords: Workplace bullying, nursing, critical discourse analysis

Background

Workplace bullying has been recognized as an issue for many workers, particularly those who work in the health sector (Einarsen, Hoel, Zapf, & Cooper, 2011). Studies indicate that the prevalence of workplace bullying among nurses is 20-30%, both in the United States (US) and internationally (Spector, Zhou, & Che, 2013). Workplace bullying is defined as persistent and repeated harmful, intimidating and harassing behaviors, from one or more co-worker towards other co-worker(s). These behaviors range from outright aggression to subtle behaviors such as ignoring a co-worker, passing on malicious gossip, or withholding information. Workplace bullying can result in physical and psychological harm to the victims (Nielsen & Einarsen, 2012). It can also result in turnover among nurses (Johnson & Rea, 2009; Simons, 2008); which is particularly concerning given the ongoing shortage of qualified nurses in the US.

While many healthcare organizations in the US have written policies that address workplace bullying, there is evidence that these policies are not being actively disseminated, and that organizations are not teaching their employees and managers how to handle workplace bullying when it occurs (Johnson, Boutain, Tsai, & de Castro, 2015; Myers, *et al.*, 2016). While nurses could get information about workplace bullying from peer-reviewed research articles, there is little evidence that most staff nurses turn to the peer-reviewed literature for information (Pravikoff, Tanner, & Pierce, 2005). Since it is probable that nurses are obtaining most of their information about workplace bullying from non-peer reviewed nursing publications (Johnson, 2013), the goal of this study was to examine the manner in which these publications discuss workplace bullying.

Methodology

Critical Discourse Analysis (CDA) (Fairclough, 2003, 2008) was used to analyze fourteen articles that were published in non-peer reviewed nursing journals, and one popular women's magazine, from 2006 to 2015. CDA allows the researcher to critically examine a given discourse - or the words and patterns of speech which are used to discuss a social issue or problem (Fairclough, 2003). The ultimate goal of CDA is to explore how this discourse might inadvertently perpetuate the problem, and how this discourse might be re-framed to bring about novel solutions to the problem (Fairclough, 2008).

The articles that were used in this study were chosen via convenience sampling. They are articles which appeared in journals that the author encountered at work, at school, or which were mailed to her. Therefore, they represent articles that a nurse might come across by chance.

Findings

Description of Sample. All of the articles in this study (n=14) were published in non-peer reviewed journals. Since the goal of this paper is to examine discourse, not to criticize the authors of these articles, the articles will not be named. A little over half (n=8) cited either an expert on workplace bullying, a peer-reviewed article, or a published book as the source of their information. Only five articles formally defined workplace bullying, the others assumed a common understanding. Statistics on the frequency of bullying were lacking; within these articles workplace bullying was variously described as an "epidemic in healthcare settings," as "all too common in nursing," and as a problem which "seems to be getting worse."

Most of the discussion in these articles centered on the reasons that bullying occurs in the nursing profession, and what can be done to stop the problem. Underlying explanations for workplace bullying included: that it has been "tolerated for too long" and has become normal behavior (n=7), that nurses are unsupportive of

new nurses and they “eat their young” (n=6), and that stressful working conditions “make a nurse angry, frustrated, overly tired, and lacking patience with staff and patients,” (n=6). However, by far the predominant discourse was that workplace bullying occurred because of the personality of the perpetrators (n=10), as exemplified in this quote: “Through his interactions with nurses, [the expert] said that a prime factor behind health care professionals participating in rude, condescending or other abusive behavior seems to be more about personality type than just working under stressful conditions.” The discourse on the personality of bullies will be discussed in the next section.

Why Bullying Occurs: Characteristics of Bullies. Bullies were variously described as unaware that their behaviors were harmful (n=6), or “mean girls” who were deliberately trying to undermine, sabotage or harm a co-worker (n=4). Within the “mean girl” discourse, bullying was described as a way to get power over another nurse, as in the following excerpt: “Pit bulls, scorpions, and snakes create conflict in an effort to feel powerful. They get their fix by undermining colleagues.”

Other nurses who engage in bullying behaviors were described as “lack[ing] insight about their behaviors.” These nurses were either described as insecure (n=5), or as “the most experienced nurses on the unit. They’re very competent, and they’re very good with patients” (n=3). In the latter category, the behaviors exhibited by these nurses were described as corrective action which was misconstrued as bullying. For example:

When California ICU nurse Jen, 46, saw that a new nurse was planning to give a patient a potentially toxic double dose of medication, she told her, “You need to look up meds you’re unfamiliar with before you give them so you don’t hurt people.” The younger nurse then reported to the unit’s charge nurse that Jen was “mean and bullying” her. “I didn’t yell at her, but I also didn’t hold her hand and gently tell her to look up things she did not know. I like precepting [training] new nurses, but a lot depends on how you communicate and on them not being defensive. It’s a two-way street,” Jen says. “There’s a feeling among older nurses that newer ones are coddled a lot more than we were. Recognize that I might be coming from a busy or stressful place. I’m only trying to help; I don’t ever mean to hurt anyone’s feelings.

Insecure nurses were said to engage in bullying behaviors because they are “cowards” who “feel threatened” by their victims. As one article said, “A bully may target someone she perceives as prettier, smarter, or stronger—or as a threat to her job.” Another article had the following advice, “Keep in mind that bad behavior reflects poor self-esteem and serves as a wall to keep people out.”

Because nurses might not be aware that their behaviors could be construed as bullying, the main advice that these articles had for victims was that they needed to confront the perpetrators. This discourse, and the descriptions of the characteristics of victims of bullying will be discussed in the next section.

Why bullying occurs, why bullying continues and characteristics of victims: Within the articles, the predominant discourse was that the new nurse, the student nurse, and the insecure nurse were more likely to be victims of workplace bullying. Being “different from the group...new nurses, float nurses or those of a different race, ethnicity or gender,” was also given as a risk factor for workplace bullying. Contradictory messages indicating that “bullies only prey on those they perceive as weak,” and “Bullies tend to victimize those they find threatening. A bully may target someone she perceives as prettier, smarter, or stronger” appeared in the same article.

While the articles contained the message that “your bullying problem is not your fault. You cannot control what someone else does or says,” they also told readers that “As a conscientious nurse, you can learn to bully-proof yourself.” By far the predominant message was that “workplace sabotage and bullying [can] be stopped... if you have the right attitude and use the right tactics.” The articles instructed nurses that they could expect to be bullied if they did not “tell the person directly that her behavior is inappropriate and ask her to stop it. If you say nothing, your silence implies the behavior is acceptable.” As another author said:

The final step in changing sabotaging or bullying behavior is to commit to not playing the perpetrator’s game—and then to implement your commitment. Don’t just talk about it. When someone does something unacceptable, call that person on it, to his or her face. Care-front it. It takes courage, but it’s worth it. The workplace doesn’t have to be toxic. The choice is yours.

When confronting perpetrators, victims were advised to use a “caring but assertive” manner, to “be careful of the tone you use when making the request,” and “use non-confrontational interaction strategies to address intimidating and disruptive behaviors.” Within this message is the implication that the primary reason that

bullying continues is that victims do not stand up for themselves, or do not confront the bully in the proper manner.

Five articles also instructed victims of bullying to report the behaviors, but only after taking action themselves. For example: "If you experience lateral hostility or violence on the job, deal with it directly and immediately. If it happens again, deal with it directly again and report it to your supervisor." One article warned that, "Be aware that Human Resources departments may tend to back management, not individual employees, so you may not get the Human Resources assistance you want or expect. This doesn't mean you should avoid reporting the incident".

While all of the articles emphasized actions that victims could take in response to bullying, only seven articles mentioned actions that organizations could take. These actions included developing leadership who could create healthy work environments (n=2), creating and enforcing policies and codes of conduct which included processes for disciplining perpetrators of bullying (n=4), and educating staff about professional behavior and bullying (n=5).

Discussion

The discourse of workplace bullying contained in these articles contains many contradictory messages. Nurses were told that it is not their fault that they are victims of bullying, but at the same time, the articles say that bullies choose victims who are primarily weak. Furthermore, the articles suggest that if victims confront the perpetrators with an assertive but caring tone, the behaviors will automatically stop. Research on workplace bullying does not support this idea; several studies have found that perpetrators can actually escalate their behaviors after being confronted by victims (Hutchinson, Vickers, Jackson, & Wilkes, 2010; Keashly & Nowell, 2011).

Most of the articles did not offer suggestions for how nurses should proceed if confronting bullies did not get the behavior to stop. One of the unintended consequence of this discourse is that nurses may feel helpless when they experience bullying. If they feel that they are being bullied because they are not assertive enough, or that the bullying is continuing because they did not confront the bully in the proper way, they may not think they will get assistance in ending the abuse. Managers may unknowingly perpetuate this message when their first response to reported bullying is to ask victims if they have confronted the bully (Johnson, Boutain, Tsai, Beaton, & de Castro, 2015). In general, the articles focused on individual solutions to workplace bullying, and discussion of organizational responses or solutions to the problem were minimal.

Another contradiction within the discourse was that perpetrators of workplace bullying were variously portrayed as purposefully engaging in these behaviors, or as oblivious to the consequences of their actions. While both scenarios are possible, it is also possible that a person might willfully engage in bullying behaviors, then deny intent to harm when confronted with their behaviors. Additionally, both the intentional and the unintentional perpetrator of abusive conduct may need extensive coaching (beyond just the victim pointing out their behavior) to learn a new way of interacting with co-workers (Crawshaw, 2010). Labeling bullies as "mean girls" or "snakes," dehumanizes them (Crawshaw, 2010), and makes it less likely that restorative approaches to the problem can be successfully utilized (M Hutchinson, 2009).

Conclusion

Since staff nurses often do not turn to peer reviewed journals as their first source of information on a topic, (Pravikoff, *et al.*, 2005), researchers, educators and administrators need to be aware of the messages that nurses are getting from the non-peer reviewed nursing literature on the topic of workplace bullying. Beginning in nursing school, and continuing into practice settings, nurse educators need to make sure that nurses have access to helpful and accurate information on workplace bullying. Organizations need to have coherent policies and procedures to deal with workplace bullying, and need to educate employees about the existence of these policies and how to use them. Finally, to combat the issue of "nurses eating their young," all nurses need to be trained in effective and supportive ways of coaching new nurses.

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Learning objectives

Participants will...

1. learn how to recognize contradictory discourses of workplace bullying.
2. gain an understanding of how discourses of workplace bullying influence responses to bullying.

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Is it a prerequisite to experience mistreatment during medical education? An explorative study on medical students

Other subtheme, but related to the main theme of the conference

Paper

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Keywords: Medical education, mistreatment, medical students

Introduction

In recent decades research has focused on discrimination and violence in medical education and training, especially since Silver (1) revealed the abusive treatment experienced by medical students. Since then it has been shown that mistreatment of medical students and residents ranges from humiliation to sexual harassment mostly exerted by clinical staff (2, 3). Additionally, mistreatment appears to peak when entering the clinical practical year and during residency. Gender differences in experiencing mistreatment are inconclusive as some studies found women reporting more mistreatment, especially in certain (male-dominated) medical disciplines such as surgery (4), whereas other studies found no gender differences in the prevalence of mistreatment in residents (5). Humiliation appears to be the most common type of mistreatment experienced by medical students and residents (6), and the phenomenon of medical education and training accompanied by humiliation is discussed as being part of the medical culture (6, 7). A comparison of various study programmes showed that medical students experienced the most mistreatment as compared to students from other study programmes (8). However, medical students are not "overly" sensitive to this issue (9), which emphasises the need to react to the humiliating practice in medical teaching and training, especially when it comes to education and training of students during clerkship and thus in clinical settings. Thus, it appears that mistreatment of students and residents is a concern in medical study programmes, which in turn demands greater attention for this issue by the medical faculty. Some studies have already pointed out that the learning environment for medical students and residents must be changed from a destructive to a constructive environment (6), additionally ensuring medical students' well-being as students and professionals (10). A destructive environment infiltrated by humiliation and mistreatment is discussed as posing the risk of passing mistreatment from teacher to learner (11). Thereby, a vicious circle is started that various institutions already aim to break (12, 13). However, the culturally enshrined practice of 'teaching by humiliation' (6, 14) can be broken only slowly.

The intention of this study was to investigate whether mistreatment and violence against medical students happens more often inside or outside medical education and whether it affects female and male students differently. In this paper we will use the term mistreatment, thereby including discrimination, harassment and humiliation.

Method and results

A cross-sectional, explorative study was conducted using the modified version of the questionnaire on student abuse (8), the organisational climate against sexual harassment (15, 16), and beliefs in a just world (17). The primary aim of this paper is to illustrate the prevalence of student mistreatment inside and outside medical education, as well as to elicit gender differences. Thus, this paper will focus only on the findings from the questionnaire on student abuse.

The questionnaire on student abuse (Modified Version of Questionnaire on Student Abuse) (8) consisted of 38 items dealing with physical and psychological mistreatment, sexual harassment and discrimination by fellow students, friends, (ex-)partners, strangers, patients, family of patients or medical faculty. Items were assessed on a four-point Likert scale including open questions for examples of mistreating acts.

Medical students were invited to participate after attending a compulsory course on Gender Medicine. The course consisted of a lecture and seminars. During the seminars students were provided with a description of the study aim and purpose and then invited to participate on a voluntary and anonymous basis. Data were analysed using frequency distribution and cross-tab calculation to compare groups. Because of the

small sample size a more detailed analysis of differences in sub-groups (e.g. such as within categories of mistreatment) was not possible.

Findings

The study group consisted of 88 medical students (women = 45, men = 43) in their 10th semester (thus shortly before starting their final year of undergraduate medical education) with a mean age of 24.7 years ($sd = 1.9$).

It was expected that students would report that most mistreatment comes from medical university staff, with other perpetrators playing a lesser role. Contrarily, our findings show that most mistreatment was perpetrated by strangers (80%) and friends (75%), even though mistreatment from faculty was still experienced by more than half of the participating students (68%). Fellow students, (ex-)partners and patients were named as perpetrators in 58%, 59% and 48% of cases, respectively. There were no significant gender differences regarding mistreatment by any of the above-named perpetrator groups.

Mistreatment was mostly experienced as screaming such as yelling, being screamed or shouted at (88%), sexual harassment including sexist jokes and sexual discrimination (51%), and humiliation (66%). Screaming was reported to be mostly perpetrated by strangers (61%), friends (60%) and (ex-)partners (51%). Humiliation was most often perpetrated by the medical university staff (41%) and friends (41%). Sexual harassment came mostly from strangers (35%) and friends (19%). Thus, it is also noteworthy that people outside the medical university play an essential role in perpetrating mistreatment.

Hardly any gender differences were found in the categories of mistreatment. However, women more often reported being humiliated by their (ex-)partner than did men ($X^2(1) = 5.47$; $p < .05$); men were more often physically attacked by friends ($X^2(1) = 6.73$; $p < .05$) or their (ex-)partner ($X^2(1) = 8.16$, $p < .05$) than were women. When looking at various types of mistreatment exerted by medical university staff, it was found that medical university staff was mostly named in connection with humiliation (41%), but not as much with regard to other categories of mistreatment. There was no gender difference in this respect.

Discussion

In this paper we highlighted the prevalence of and perpetrator type behind mistreatment of medical students. We aimed to investigate the prevalence of mistreatment inside and outside the medical university as well as to search for gender similarities and differences. It appears that medical education is based on humiliation of students (6, 14), and mistreatment of students is more often found in medical students than in students at other faculties or study programmes (8). Mistreatment of medical students also appears to peak during the clinical practical year and during residency (18). The students in this study had already obtained some practical experience from medical clerkships. Thus, it is assumed that to some extent mistreatment reported by the student was also experienced during clerkships. However, the questionnaire did not ask specifically whether the mistreatment took place during clerkship or any other period of medical education. It is expected that there is a substantial difference in the experience of mistreatment during clerkship and in lectures. Most mistreatment is presumably experienced during clerkship (or later in residency) when medical students start to interact with clinical staff on hospital wards. Thus, during their clerkship medical students can be experienced as a strain that has to be coped with on top of patient care and research duties. This strain could also lead to exhaustion and contribute to the vicious cycle of humiliation.

Despite the fact that various studies have been conducted on gender discrimination in physicians (19, 20) hardly any gender differences were observed regarding mistreatment in medical students. Thus, one assumption could be that medical students are mistreated regardless of gender and that no benefit derives from being male in a (today often a formerly) male-dominated profession. This assumption would also relate to humiliation having the “function” of “toughening up students”, providing them with the same kind of “harsh” and mistreating tone of medical education that teachers experienced during their education; thus the mistreating and humiliating behaviour is passed from teacher to learner in an endless and relentless spiral (11).

Several efforts have been made to improve the learning and teaching environment in medicine. For example, the possibility for safe reporting, implementation of policies to fight abuse in the given medical school, introduction of training to acquire skills for dealing with mistreatment, knowledge about mistreatment and awareness for this issue as well as monitoring the rates of mistreatment in medical education have been discussed as first steps toward changing this specific aspect of culture in medicine (12). However, there is still a long way to go as change is slow and the rates of mistreatment are dropping only slowly (12, 13).

Because of the cross-sectional design of our study our findings do not permit any assumptions to be made about decreasing or increasing rates. However, we received information on the extent of mistreatment in medical education from medical university staff and patients as well as patients' relatives. Despite our small sample, this study permits us to conclude that patients and their relatives were associated with mistreatment of medical students to a lesser extent than were other groups (medical university staff, strangers, friends, fellow students). The extent of mistreatment by medical university staff (68%) is alarming and demands that further steps be taken. We also need to know the types of situation that provoke humiliating behaviour in medical university staff and how students react, as well as long-term consequences with regard to their attitude and their manner of patient care once they are entitled to practice medicine. By gaining knowledge about the types of situation where mistreatment happens, interventions can be implemented more specifically. We thus assume that interventions that target mistreatment not only on a general level, but that also provide teachers and learners with tools, behaviour alternatives for avoiding and confronting mistreatment might bring about more sustainable change. Additionally, the consequences that mistreatment has on patient care might permit the issue of mistreatment of medical students to be sustainably emphasized as one of the goals of medicine is to provide the best possible quality of care for patients. Other studies have shown that rates of mistreatment are dropping only slowly (12, 13). Thus, it can be assumed that the need to change behaviour and to avoid humiliating students in order to "toughen them up" will be supported by the commitment to improve patient care, which is a relentless pursuit in medicine.

Additionally, we found that mistreatment of medical students only partly relates to mistreatment perpetrated by medical university staff. It appears that a greater threat lies outside the medical university; thus, strangers, friends and also (ex-) partners were named as sources of mistreatment by more than half of the participating students, namely 80%, 75% and 59%, respectively. As these people are not (necessarily) encountered inside the medical university, we have to consider not only the effect of mistreatment suffered inside medical education, but also social environmental threats.

In Austria there are hardly any university campuses; instead students live mostly in private accommodations. Thus, students are also integrated in the social environment outside the university and permanently confronted with people not working or studying at the university. Moreover, students can have a different nationality or be from other parts of Austria. This could also cause tension, especially outside the university, as there is a physician's shortage that is predicted to increase in the future (21-23). Thus, it is feared that students from other countries will go back home after completing their studies.

Even though it can be argued that it is not the medical university's responsibility to fight mistreatment stemming from the social environment outside the medical university, we have to consider how these experiences influence our future physicians. Thus, we propose that medical university campaigns aiming at raising awareness, education about mistreatment and training in skills to fight mistreatment should target not only threats from inside the medical university, but also threats from outside the medical university. Awareness cannot be restricted to the medical university itself, but has to tackle more than just that.

Acknowledgements

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Learning objectives

Participants will...

1. be aware of mistreatment of medical students.
2. distinguish between mistreatment inside and outside of medical education.
3. consider different forms of mistreatment when planning research on mistreatment of medical students.

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Autism and aggression

Other subtheme, but related to the main theme of the conference

Paper

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Keywords: Autism, Aggression, Violence, Criminal Autistic Psychopathy

Introduction

It has been recognised from the 1940s, that serious aggression could be associated with Autism. This was first described by Hans Asperger (1944) [1]. This presentation examines the causes of aggression in Autism. The aggression is very much a Spectrum, going from common behavioural aggression to serious criminality. It is particularly seen in forensic psychiatric hospitals. This paper describes a new concept of criminal autistic psychopathy, (Fitzgerald 2010) [2]. To describe persons with Autism who get involved in serious criminal activities from grievous bodily harm to murder.

Autism is characterised by poor eye contact, problems reading faces, problems with social know-how, naïve and immature, problems sharing, problems turn-taking, speaking with an unusual accent, repetitive language, preservation of sameness, narrow interests and sensory issues. Criminal autistic psychopathy is often confused with schizoid personality disorder, with which it does overlap, paranoid, borderline schizotypal, avoidant antisocial or narcissistic personality disorder. To engage with the proper treatment, the Autism diagnosis is necessary, as this leads therapists to give mind reading skills therapy, social skills therapy, pragmatic language therapy, etc. Asperger (1944), recognised the serious aggression that could be associated with people on the Spectrum of Autism and Aspergers Syndrome. Aspergers Syndrome remains in ICD X.

Sensory issues are part of Autism now and can be critical to aggressive outbursts or even more, by persons with Autism, when they experience sensory overload, which they can very easily. Persons with criminal autistic psychopathy are often fascinated by poisons, guns, serial killers etc. These persons are often extremely controlling and dominating and when their rituals are interfered with, this can lead to serious criminal aggression. Criminal autistic psychopathy also overlaps with general psychopathy as described by, (Fitzgerald 2010).

These persons with criminal autistic psychopathy are extremely difficult when their personal space is invaded. They have major social interactional skills difficulties. Very often they tend to live alone and to have chequered work histories. They will often be regarded as being somewhat, “loners”. People will often have noticed differences in their personality from average people, but will have difficulty putting a diagnosis on the difference. This will often be observed in hospital settings. In hospital settings they are extremely rigid and unchangeable. Some of them do later in life develop psychosis as well. ADHD is another very common overlap as is Oppositional Defiant Disorder. They have very diffuse identities and difficulty separating fact from fiction and suspicious. They will show emotional dysregulation and will have major problems with impulse inhibition. Their empathy deficits are the most central feature. Some are fearless, novelty seekers, show poorly daily life management, show pragmatic language problems and show poor ability to read other people’s minds. They have particular difficulty reading emotions from faces and eyes. The condition is far more common in males than females, but can occur in females and an example would be serial poisoners or health professionals getting involved in murdering patients, e.g., Harold Shipman etc.

Conclusion

When patients are on hospital wards and are observed to be very disruptive, easily irritated, putting their hands over their ears, shouting, pushing and being inflexible and rigid, then undiagnosed Autism Spectrum Disorder should be considered. This is still called Aspergers Syndrome in ICD X. They can show all levels of violence from hitting to homicide. A new category of Autism has been described called Criminal Autistic Psychopathy to cover this category of Autism, criminality and Aspergers Syndrome, (Fitzgerald 2010, 2015). [3], [4]. They need nursing staff knowledgeable about Autism or at the very least the staff need to consult with medical professionals, expert in Autism interventions. The fundamental deficit is a problem with understanding of their own emotions by these patients and a problem understanding other people’s emotions; that is a problem

with theory of mind. The prevalence is about 1 in 60 in the general population. This means this is far more common on hospital wards than realised.

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Learning objectives

Participants will...

1. Become acquainted with a new concept of criminal autistic psychopathy.
2. Learn how to identify and treat Autism in aggressive episodes the health service.

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Application of Kinaesthetics to decrease challenging behaviour during support persons with dementia

Other subtheme, but related to the main theme of the conference

Poster

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Keywords: Kinaesthetics; challenging behaviour

Background

Challenging behaviour occurs during support with activities of daily living in the care of persons with dementia. This makes demand-oriented care more difficult or at times impossible and significantly influences the quality of life of the affected individuals. As a concept to improve motion perception and self-control, Kinaesthetics offers a solution-oriented approach through specific and adapted communication. The concept has been applied for many years to the care of persons with dementia. To date, there are no studies on how Kinaesthetics influences dementia-related challenging behaviour during support with activities of daily living.

Objective

To develop an impact model that reduces challenging behaviour during support with activities of daily living in persons with dementia. The research project is divided into three phases according to the guidelines of the Medical Research Council for complex interventions:

1. Describe evidence base for Kinaesthetics in dementia-related challenging behaviour.
2. Identify the components of the Kinaesthetics intervention and their interrelationships.
3. Develop and test the Kinaesthetics impact model.

Method

Exploratory sequential mixed-methods-design:

1. Systematic review
2. Four focus group interviews with Kinaesthetics experts and nursing professionals in two different institutions.
3. 193 video recordings during support of daily life activities of 14 persons.

Results

Within the framework of the care of persons with dementia, the central concepts of „Communicating through movement“ and “Every day is different” could be identified by Kinaesthetic trainers in terms of context, intervention and outcome. Research has shown that Kinaesthetics trainers aim for homogeneity in their care and that the interventions of the professional nursing staff take place on an ad hoc basis. The results of the current research study have shown to date that the application of Kinaesthetics can prevent challenging behaviour due to more effective communication.

Learning objectives

Participants will...

1. learn that Kinaesthetics can prevent challenging behaviour due to more effective communication.
2. appreciate that Kinaesthetics has a specific understanding regarding an attitude of give and take in supporting in the daily activities. This will encourage people with dementia and give you grip in the search for identity as a human being with dementia.

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The relation between substance use and violence

Other subtheme, but related to the main theme of the conference

Poster

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Keywords: Substance use, violence, anger

Abstract

In worldwide substance abuse has varying rates, and almost all countries are negatively affected by the drug. The most negative conditions are violence, crime, AIDS and the other infectious diseases and also cause social structure collapses (Özmen and Kubanç, 2013).

According to The Turkish Monitoring Centre for Drugs and Drug Addiction (TUBİM) research was found 2.7% prevalence of substance use in the general population. In World Drug Report (2014) data, it was reported that 183 000 death due to the substance uses, in 2012. In Turkey, the substance use death rate was found 416 people in 2013 cause by indirection way (TUBİM, 2014). The rates were increased between the years (TUBİM, 2013; TUBİM, 2014). The reason of interpersonal violence of death was found %40.7 caused by murder, firearms, cutting wounds injury. There is a significant correlation between substance abuse/addiction and interpersonal violence (Hoaken and Stewart, 2003). Most of the users cannot reach or seeking the treatment. Despite they can reach the treatment, the relapse rate is higher for maintaining their treatment (Hoaken and Stewart, 2003; Cornelius *et al.*, 2003; Domino *et al.*, 2005; Yilmaz *et al.*, 2014).

Substance abuse and interpersonal violence cause by the risk factors are grouped under three headings. First risk factors are including individual characteristics such as anger expression, stress, anxiety, depression status, impulsivity, hyperactivity, behavior problems including sensation-seeking and attention problems, accessing to substance or resources, the desire to gain substance, aggression, mental problems, being male gender, being young, academic performance impairment and schools suspended. The second risk factors are including family issues such as having a users in t heir parent, low parental monitoring, have poor social support and family conflict, low expectations of family, family rejection and weak attachment to family. The third risk factors are social and community parameters such as the high level of substance availability, low socio-economic status and irregularities residence environment (Atkinson *et al.*, 2009; Eftekhari *et al.* 2004).

Especially violent crimes can be processed to obtain substance or reach the resources or substance. Violence is often a necessity in terms of problem-solving in the discussions that occur in irregular and illegal unregulated businesses. Additionally it may occur with high thrill seeking without knowing the consequences. The other reason of aggression can be caused by the substance type and the consequence of the substance, like intoxication, neurotoxin, and withdrawal symptoms (Hoaken and Stewart, 2003). Substance users and alcohol users cannot control their anger feelings and be more aggressive when compared who not use substance (Sharma *et al.*, 2012). It is important for mental health services to determine the anger expression in substance abuse users and, variables of affecting anger. It can lead to understand the patient and real emotion under the anger feeling.

Learning objectives

Participants will...

1. learn about related factors of violence in substance use.
2. learn about the background and risk factors of violence in substance use.
3. Take risk factors of people who use substance into account in order to understand why they get more anger compared with other people.

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Supporting Organisations



Announcement

**The Sixth International Conference on
Violence in the Health Sector
will be held from the 24th till the 26th of
October 2018 in Toronto, Canada.**

**Venue: Holiday Inn Toronto International Airport Hotel,
970 Dixon Road, Toronto, Canada**

**The call for abstracts will be issued in October 2017 on the
conference website www.oudconsultancy.nl.**

Please reserve these important dates in your agenda.

Looking forward to seeing you in Toronto, Canada in 2018.



Broadening our view - responding together

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 this fifth conference are:

1. To broaden our understanding of the causes and consequences of violence in health settings based on up-to-date evidence from the multiple perspectives of violence – including biological, psychological, experiential, legal, political, and societal.
2. To present and exchange experiences in handling violence, through violence prevention and/or violence management, and seek convergence on promising and feasible collaborative responses.

The key theme of the conference on this occasion is to broaden our view and to respond together. This is reflected in the broad array of themes presented in the abstracts as well as in keynote addresses of the meeting which address a range of topics related to violence including political violence and its appeasement, legal issues, communication with stakeholders, challenging behavior in the health sector, neuro-cognitive dysfunction, policy issues, and even a special workshop demonstrating the role of dance in a choreography of catharsis.

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