Second International Conference on
Violence in the Health Sector
From Awareness to Sustainable Action

Dr. Ian Needham
Mr. Kevin McKenna
Dr. Mireille Kingma
Mr. Nico Oud

KAVANAH

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Mr. Nico Oud

Editors

Violence in the Health Sector

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second International Conference on
Violence in the Health Sector -
From Awareness to Sustainable Action

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Preface

In October 2008, an inaugural international conference addressing workplace violence in the health sector entitled 'Together, Creating a Safe Work Environment' was held in Amsterdam. At this conference 162 presentations were delivered which involved the work of 369 authors from across the globe sharing their research, their experiences, and their solutions (Needham et al. 2008).

The conference articulated the consensus that violence in the health sector compromises the quality of the care experience of both recipients and providers. The impact of the problem extends the service setting and is also a major concern from both occupational health and safety and public safety perspectives.

The conference concluded with a call for the second conference to broaden the exploration of the problem, and to extend the epidemiological debate to include greater emphasis on sustainable strategies to prevent, manage, and mitigate against the very significant impacts of the problem. This aspiration is materialised in the large number of conference contributions on the sub-theme "Strategies and initiatives to manage violence in the health sector at local, institutional, organisational and (inter) national levels: lessons learned".

The submission of 191 abstracts to the call for abstracts from 42 countries for the 2010 conference confirms the continued interest internationally in this issue. Sadly, attempts to raise funds to support participants from less affluent areas of the world reflects the current global economic recession, and the conference organisers regret that many worthy papers had to be withdrawn due to the lack of finance.

Amsterdam was chosen as the venue for the 2010 Conference on Workplace Violence in the Health Sector. Amsterdam as a venue with its geographical centrality in Europe is no stranger to global meetings. The first World Humanist Congress which established the formulation of the principles of Modern Humanism was held here in 1952. There are parallels between this historical event and our own conference in that both strive to improve the human condition by employing ethical, rational, democratic, imaginative and creative solutions which combine personal liberty with responsibility.

The theme of the 2010 conference – From Awareness to Sustainable Action – deals with the following aspects of Violence in the Health Sector:

- Patterns of client aggression and violence against staff
- Awareness promotion, visibility, and public attention
- Environmental and specific care setting considerations including urban and rural
- Impact of violence including psychological, professional, ethical, economic, financial, legal, social, and political issues
- Methodological issues regarding researching violence in the health sector
- Patterns of staff and institutional aggression and violence against clients
- Patterns of staff aggression and violence: including horizontal and vertical violence, and gender and discrimination issues
- Stigma, blame and attribution issues
- Strategies and initiatives to manage violence in the health sector at local, institutional, organisational and (inter)national levels: lessons learned
- Training and educational issues regarding clients and workers.

The exciting programme of plenary presentations by invited experts, papers, workshops, seminars and posters will broaden both the perception of the challenges, and the exploration of options for sustainable action. This duality of focus will therefore build upon the epidemiological platform of the previous conference and provide a forum for the exchange of strategies, research and ideas related to sustainable action. The discussions and debate, in addition to the conference networking, will inform the improvement efforts of participants, and readers of their contribution, far beyond the temporal or geographical boundaries of the conference itself.

Hence, it is our pleasure and honour to present you with this collection of thought-provoking abstracts. We wish you all a very successful conference and an exciting stay in the beautiful City of Amsterdam.

Reference
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Chapter 1 - Keynotes

Stalking as violent behaviour and prevalence of abusive encounters in the workplace of family physicians

Keynote speech

Donna Manca, Baukje Miedema, Ryan Hamilton, Anita Lambert-Lanning, Francine Lemire, Vivian R Ramsden, Sue Tatemichi
Department of Family Medicine, Edmonton, Alberta, Canada

Introduction

Family physicians may encounter harassing behaviour from their patients. The aim of this presentation is to increase awareness of these phenomena and explore approaches that have the potential to mitigate harassing behaviour. Sources of information include a family physician's personal experience of a stalking incident combined with information gathered from the literature and research exploring the prevalence of abusive encounters in the workplace of family physicians.

The case – based upon a case description and reflection previously published[1]

A relatively new female patient to my practice was assessed and diagnosed as suffering from depression. I provided her with a one-week sample of antidepressant medication and advice regarding how to take the medication. She decided to take all of the medication at once with a case of beer. She felt ill and went to an emergency department of a local hospital. At the hospital, a computerized axial tomography (CAT) scan was done of her head. This showed some brain atrophy. She was likely told by the physician in emergency that her brain had shrunk. She became hostile and declared that she wanted to kill me, her family physician, for shrinking her brain. Psychiatry was consulted and evaluated the patient finding her to have homicidal thoughts. I was notified about the patient's violent intent and advised not to meet alone with the patient. To avoid "abandoning" a patient who required medical care it was suggested that I find a male colleague who would accept the patient under his care and meet with him and the patient to transfer her care to his practice.

It was difficult to find a male colleague willing to see the patient; however, an associate who shared the same practice location and after-hours schedule was willing to assume responsibility for the patient. Shortly after transferring care, I was paged by the patient after-hours. I answered the first few pages from the patient assuming that they were medical emergencies only to find myself been verbally harassed by the patient.

My male colleague told the patient to cease any further contact with me and transferred her to another physician at different practice location. Despite this, the pages occurred day and night interrupting my activity and sleep. The patient also obtained my home telephone number and left messages that frightened my husband and children. She was also seen loitering at my office building. I feared that the patient might contact and disturb distant family members with my surname so I warned them of the potential dangers.

I became vigilant about security especially when engaged in late-night after-hours work at the hospital and nursing homes. I documented every episode and kept copies of threatening messages. I contacted my licensing body (the Alberta College of Physicians and Surgeons) for advice on when and how to involve the police. It was suggested that the patient be notified in writing and warned that if the behaviour continued the police would be contacted. I sent a warning letter to the patient.

The patient came to my office and yelled at my staff "no more letters" frightening them. My staff called the police. The patient had left the office by the time the police arrived and an incident report was made out; however, my office staff were told that nothing could be done until violence occurred. This incident occurred at a time when anti-stalking or harassing laws had not come into effect.

The stalking escalated. The patient attempted to contact me through different psychologists who would telephone me and indicate that the patient was sorry and that a meeting with the patient would help her to heal. This happened with different psychologists on a number of occasions. I explained that they were to cease further contact with me since the patient was stalking me and that I perceived their contact as another method of harassment. False complaints were then launched with the police. When the police reviewed the threatening tape recordings I had received from the patient, they realized that the claim was false and advised the patient to cease this behaviour. A false complaint was then submitted to my licensing body. The Canadian Medical Protective Association and the College of Physicians and Surgeons helped to reinforce the message to the patient that this behaviour must cease.

Workplace violence was a common experience for me in my early years as a trainee that continued when I practiced as a family physician. I have experienced violence from patients, their families, colleagues and even the medical system. I never anticipated that a woman would stalk another woman and was shocked and deeply disturbed by this episode. During this episode, I became aware that two of my female associates were also experiencing stalking by different female patients. I wondered how often family physicians experienced violence and stalking in the workplace. I met researchers and colleagues who had that same question. I collaborated with the authors on this paper on a pan-Canadian research project titled "Family Physicians and Workplace Abusive/Violent Encounters: Prevalence, Incidence, Impact and Strategy" with Dr. Baukje Miedema as the Principal Investigator.

Methods (A National Survey)

The research team used a seven page cross-sectional survey to obtain quantitative information from a random sample of 3802 active/practicing family physician members of the College of Family Physicians of Canada over several mailings between November 2008 and April 2009.[2] The survey was a modification of a survey developed by a New Zealand research team.[3] Part I of the survey included demographic questions and Part II included questions about the career prevalence and frequency of 14 different types of abusive encounters ranging from minor to severe. Minor incidents included: disrespectful behaviour, bullying, verbal anger, verbal threats and humiliation. Major incidents consisted of: physical aggression, destructive behaviour and sexual harassment. Severe abuse included: assault, assault causing injury, attempted assault, sexual assault and stalking. A five-point Likert scale ("never" to "very often") regarding the frequency of abuse was utilized. Part III inquired about the monthly incidence of abusive encounters by perpetrators, ranging from minor to severe. Part IV asked questions about policy and actions. Face validity was obtained through expert reviews by several family physicians in Fredericton, New Brunswick.

The College of Family Physicians of Canada's (CFPC's) National Research System (NaReS) operationalized the survey for the study using a modified Dillman approach. This survey was pilot tested by NaReS with four English and four French family physicians across the country. Some minor changes were made to the English survey while for the French survey several terms were altered to mirror the language used in the 2007 National Physician Survey.[4] The pilot surveys were not included in the final sample. Members of the research team, retired, sustaining, specialist; as well as, resident (physicians in training) members were excluded. The data was entered into Statistical Package for Social Science 15.5 (SPSS15) software for analysis. Research Ethics Board approval for the study was granted by Dalhousie University, the University of Alberta, and the University of Saskatchewan.

Results

Survey Results: The career prevalence of abusive encounters in the workplace of family physicians have been published in a paper titled "Prevalence of abusive encounters in the workplace of family physicians: A minor, major or severe problem?" in the Canadian Family Physician journal.[2]

Of the 3802 surveys mailed (458 French and 3344 English), 770 (20%) were completed and analyzed for lifetime workplace violence prevalence (105 French and 665 English). On comparing the French-speaking non-respondents to the respondents (78% vs 23%), they were of a similar mean age (41yrs vs 39yrs), there was a higher proportion of women (40% vs 62%) and a lower proportion of men (60% vs 38%) who responded to the survey. When comparing the English-speaking non-respondents to respondents (80% vs 20%), they were of a similar mean age (44yr vs 44yrs), there was also a higher proportion of women (46% vs 56%) and a lower proportion of men (54% vs 44%) who responded to the survey. Hence the respondents were of similar age to non-respondents and more women than men responded to the survey.

It was clear that almost all of the participants had experienced some level of abuse. Of the 774 respondents, 98% indicated that they had experienced at least one incident of "minor" abuse, and 75% reported "major"

abuse during their career as a family physician, including sexual harassment or physical threats from a patient.[2] What is disturbing is the high level of severe abuse experienced by a large number of the physicians; 39 % said they experienced at least one incident of "severe" abuse, which included being physically attached, injured, sexually assaulted or stalked during their career.[2] Nine out of 10 family physicians reported being victimized by patients, while 7 out of 10 identified family members of patients as being responsible for the abuse.[2]

Of the respondents, 14% (104/766) indicated that they had experienced at least one episode of stalking.[2] Of these, 11% were male physicians and 16% were female, the slightly higher proportion of women was not statistically significant.[2] Hence, in our study both female and male physicians were at a similar risk of experiencing a stalking incident during their career.

When we the relationship between physician gender was examined, some patterns emerged: women were more frequently bullied ($P = .026$) and sexually harassed ($P < .001$), while male physicians were more often verbally threatened ($P = .011$), humiliated ($P = .007$), and assaulted ($P = .001$), and were more likely to experience destructive behaviour ($P = .005$).[2] The sexual harassment prevalence rates for male physicians were 31% and 61% for female physicians.

Work Setting and Profile of Perpetrators (survey and literature)

The work setting was also associated with the level of abuse. The level of violence related to geographic location including; inner city, urban or suburban, small town, and rural or remote was assessed. Working in urban or suburban areas and small towns ($P = .039$) were associated with more minor abusive events and working in a small town ($P = .009$) was associated with more severe abusive events. Physicians who worked in emergency departments either full-time ($P < .001$) or on occasion ($P < .020$) or who worked in nursing homes ($P = .001$) were more likely to experience major abusive incidents.[2] Severe abusive incidents were associated with working in an emergency department as a main practice setting ($P = .001$), doing house calls ($P = .029$), and working in the hospital as a main practice setting ($P = .032$).[2]

Working in emergency departments carried a significant risk and our finding of increased violence with working in an emergency department has been well documented.[5, 6] Less well documented is the finding of hospital work being associated with a higher risk of severe abusive encounters than those family physicians in private practice settings.[2] Physicians that work in lower social economic settings[7], and who provide after hours care[7] may also be at an increased risk of encountering abusive behaviours. Characteristics of patients associated with increased violence include those who are; socially disadvantaged; suffering from mental health illness; or, who have addictions to alcohol and drugs.[7]

Methods of harassment (case description and literature)

In my stalking case, I experienced verbal abuse and threats, unwanted communication through the telephone and pagers, and complaints to professional bodies. Common methods of harassment of physicians include: verbal abuse and threats;[2, 7, 8] unwanted communication (telephone, letters and email);[1, 9, 10] unsolicited gifts;[10] surveillance;[1, 10] and property damage[2, 7, 9, 10] or theft.[7] Less common methods consist of: complaints to professional bodies;[1, 10] physical violence;[2, 7] sexual harassment;[2, 7] and, ordering or cancelling services on the victim's behalf.[10] Frequently, more than one method is used.

Personal impact of harassment (case description)

This episode had a severe impact on my practice and me. My practice was interrupted during the stalking episode. For example: I was called away from another patient with an acute abdomen in the emergency department to answer an emergency page from my stalker. Other patients had to reschedule appointments due to interruption of my office when I met with police, the College of Physicians and Surgeons and my lawyer. Some patients became impatient when they had to wait past their scheduled appointment time due to unexpected interruptions from the police visiting my office or when I needed to answer telephone calls and pages instigated by the stalker. The financial impact was significant with lost appointments and cancelled clinics due to the time required to respond to the College of Physicians and Surgeons, and the police. The personal impact was devastating. I was frightened to make nursing home visits and hospital visits at night. I eventually gave up my nursing home privileges to avoid these visits. I had trouble sleeping and felt fearful. I debated leaving medicine and took up marshal arts to build my confidence. I obtained a home security system and a dog. I decided to do something about this by pursuing research.

Discussion

What do these findings mean? – How common is workplace violence and stalking? Who is at risk?
Certain occupational groups have been identified to be more at risk for workplace violence including: health care workers; correctional officers; social service employees; teachers; municipal housing inspectors; public works employees; and, retail employees.[11] Of all the health care professions, nurses and family physicians are at the greatest risk of encountering abusive behaviours,[12] and some health care workers have documented that they have been in receipt of verbal abuse on a daily basis.[8] Little was known about the situation among family physicians in Canada until recently, however, a survey of Australian physicians indicated that 64% (336/528) of respondents had experienced violence in the previous year and of these 13% (68/528) indicated that these encounters were considered to be high-level violence such as physical abuse and sexual harassment.[7] Our survey identified workplace violence as a notable problem with a high prevalence of major and severe violence experienced by family physicians during their career. Though the response rate was low (20%), this national survey[2] is the largest and most comprehensive assessment of family physician workplace abuse in Canada, and even if we assumed that none of the non-respondents had been abused, we would still be able to safely report that at least one in five family physicians are subjected to abuse at work, one in seven to major abuse and one in 12 to severe abuse. This high prevalence of major and severe abuse is worrisome.

High-level violence like stalking may be more common than we realize. The fact that 14% (104/766) of respondents indicated that they have had a stalking experience is not surprising since a New Zealand study reported that close to 2% of general practitioners had experienced being stalked in the previous year.[3] Eleven percent of Italian mental health professionals experienced stalking in their careers with male mental health professionals being more likely to be stalked;[13] however our study did not find a gender difference. Health care professionals are overrepresented in stalking-victim populations.[9] Women stalking women may be more prevalent in this group.[14] A case study of 190 stalkers found 21% (40/190) were women and of these 40% (16/40) focused their attention on women professional contacts such as psychiatrists, psychologists and family physicians.[14] Family physicians provide comprehensive care in a wide variety of settings; hence, their routines and schedules are public knowledge making them particularly vulnerable to harassment or violence such as stalking by patients. Mental health clinicians are at also at high risk of experiencing stalking. One New Zealand survey of 550 psychiatrists and mental health nurses found that women were more likely than men to have experienced one or more stalking behaviours.[15] This pilot study obtained a 31.3% (280/895) response rate and identified an overall stalking prevalence of 70.4% (197/280) with clients representing nearly half of the stalkers.[15] Another survey of 400 mental health nurses in the UK obtained a 28% (112/400) response rate; of these respondents 50% (56/112) reported at least one stalking experience.16 In this study the majority of the victims were female (78.6%) and the majority of the stalkers were males (82.1%).[16]

Certain physician's practices and patient characteristics may be associated with a higher risk of violence. Women health care workers are at greater risk than men,[8] and a survey of Australian urban general practitioners found that women physicians were at higher risk than male physicians.[7] Our study identified gender differences in the types of abuse experienced with a higher proportion of women experiencing sexual harrassment.[2] Of interest, one study identified that 76% (321/422) of women physicians report sexual abuse during their careers.[17] Other studies found that younger and more inexperienced physicians were at higher risk of violence than those with more experience.[7]

How does workplace violence impact physicians?
Violence in the workplace of physicians has a negative impact of the individual and their family; as well as, impacting on their quality of life.[18] Workplace violence can also impact the individual's work and some may withdraw service from particular environments perceived to be at high risk of abuse or consider taking measures including personal protection in response to the fear.[5]

Averting violence by setting healthy physician patient boundaries
Early recognition and intervention may avert problems. Unfortunately, barriers to early intervention may delay action. A delay in recognizing potential problems from boundary intrusions may occur when there is gradual erosion of physician patient boundaries. Some physicians may also cope through denying or refusing to acknowledge the problem.[10, 19] Others may believe that they should tolerate their patients' inappropriate behaviours or that the abusive behaviour may be equated with incompetence.[10]

Reviews of the literature and case studies indicate that problems can be averted by: setting clear boundaries; addressing intrusions in a firm limit-setting manner; taking threats seriously and when necessary; and, consulting the authorities early.[10, 19, 20] One survey found that stalkers were more likely to cease harassing behavior when specifically asked to stop.[21] With stalkers, it is important to cease all contact with the stalker

since further contact may reinforce the behavior.[10, 19] Physicians should terminate the relationship when unwanted behavior persists despite warnings. Once terminated, all further correspondence should be avoided.[10, 19] Physicians may be hesitant to terminate relationships in some settings due to the perceived medical and legal implications that could result from abandonment of care.[10] Developing and advertizing policies that set clear boundaries and protect health care workers may be helpful.[10, 19]

What can we do to protect ourselves?

Physicians may avoid problems by protecting their personal information. Literature reviews suggest avoiding listing private numbers; addresses; and, personal information in media that the public can access (telephone books, WebPages, professional organizations). [10, 19] Post office boxes or answering machines can be used as a resource to protect personal information.[10, 19] Telephone providers may have services that can prevent your personal phone number from being displayed on telephones with call display or to assist with documenting harassing telephone calls.[1]

When concerns arise, it is helpful to keep detailed notes and document every incident including dates and times of events as well as any discussions regarding the situation.[10, 19] It is wise to keep these in a separate location from the patient's file.[1] Any other materials such as letters, pictures, gifts, and tape recordings should also be kept since returning items to the perpetuator may aggravate the situation, and they may be needed as evidence should the situation escalate. [19]

Conclusions

Boundary intrusions from patients and others are more common than we realize in the workplace of physician. Our research illuminated the serious issues with the level of violence in the Canadian workplace of family physicians. We hope that increased awareness of the problems will open discussions to explore and identify options for optimal management of workplace abuse and violence. A change in the culture of the physician's workplace to encourage open discussions of these uncomfortable situations may assist in improving the situation. Increased awareness of the risk of workplace violence and how to set healthy boundaries may assist with addressing boundary intrusions early and help avert some problems. We can educate physicians and residents (physicians in training) about how to set healthy boundaries and better communicate with patients. Work settings should be structured with safety in mind, such as ensuring the physician has access to the door when in a room with a patient to avoid being barricaded in a room by a patient. Physicians and their staff could develop protocols to deal with potential violent situations in the private office setting. Further research can help develop informed legislation and policies that establish laws and improve policies to deal with intimidation, including mechanisms to assist physicians with transfer of care.

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Correspondence

Ms Donna Manca
Research Director
Department of Family Medicine
901 College Plaza,
Edmonton, Alberta
Canada
T6G 2C8
+1 780 492-8102
dmanca@med.ualberta.ca

Violence in healthcare: an ethical perspective

Keynote speech

Guy A.M. Widdershoven
Department of Medical Humanities, VU University Medical Center Amsterdam, Amsterdam, the Netherlands

Introduction

Healthcare professionals usually chose their occupation because they care for other people and want to help them to live their lives as well as possible. This implies a positive attitude to care-receivers and colleagues, which are normally reciprocal; patients and co-workers will in general react positively to and cooperate with the caring attitude of the care-provider. Yet, this is not always the case. Healthcare professionals are increasingly confronted with opposition, verbal abuse or even physical force, both by patients and colleagues.

How to deal with such, often unexpected, events? Ethics provides various ways of approaching situations of violence. One is to set rules which protect the rights of both the professional and the person who acts as a threat. Another way is to focus on relationships and processes of negotiation. In my presentation I will first go into the assumptions behind the two approaches. Next, I will illustrate the differences with a case story from psychiatric practice. Finally, I will explain how a relational approach can be fostered by a specific ethical intervention, Moral Case Deliberation.

Rules versus relationships

From an ethical perspective, the problem of violence in healthcare can be approached in two ways. One is to formulate strict rules and create safeguards so that these rules are actually being followed. Within the confinement of the rules, people are free to do what they like. The basic idea is that people have certain rights, which should be protected by the law. The law protects both the rights of healthcare providers and patients. This approach has some shortcomings. First, it assumes that such rules can be formulated in an objective way, and acknowledged by everyone in society. This assumption seems to be at odds with the current situation, in which rules are often interpreted differently and negotiated by 'the offender'. Second, the motivation to follow these rules is external. People obey them, not because they acknowledge that they are right, but because they do not want to get in trouble. Third, interventions will be late. After the fact, sanctions follow, but as long as the rule is not broken, no action is taken. This means that there is no attention for prevention (if we leave out the, questionable, idea that the sanctions will prevent future breaking of the law).

A second way to approach the issue of violence in healthcare is to see it as part of the moral relationships between those involved. These relationships are structured by negotiations about what people owe to one another, and what they are responsible for (Walker, 1998). The basic idea is that people come to see what is important in a situation by a process of interaction, in which they learn from one another. People learn what rules entail by responding to each other. First, this approach does not assume that rules are objective and universal. When rules are interpreted differently, this does not mean that one interpretation is right and the other is wrong, but that these interpretations should be investigated and that the participants should try to understand each other's perspective. Second, this process of investigation may result in a joint understanding of the situation and of what is proper, which serves as an internal motivation for action. Third, the process of negotiation does not start when a rule is broken, but is always already at work. This implies that subtle solutions can be found in dialogue, so that a major clash may be prevented.

A case story

The differences between the two approaches can be illustrated with a case story. The case shows both approaches at work in dealing with a patient in crisis.

Hans is brought to the psychiatric ward of the hospital with an ambulance. He has an intellectual disability, and has somatic and psychiatric problems. He has been tied to the bed by four nurses. The reason was that he was crying loud, scolding at people and behaving aggressively. The nurses at the ward say: "This is a candidate for separation". Yolande is the nurse in charge. She proposes not to bring Hans to the separation room, but to a room for one person. Hans is brought to the room, and Yolande tries to get in contact with

him. She asks the nurses who have brought him in, whether Hans has acted aggressively. They say his aggression was merely verbal. Yolande proposes to untie Hans. As soon as the ties are gone, Hans becomes more relaxed. Yolande introduces herself to Hans. He responds by telling her his name. Yolande asks whether he wants a cup of coffee. He accepts the offer. Yolande says she can imagine that Hans has been through quite a heavy experience, and invites him to tell about that. In the end, Hans eats a sandwich, takes his medicines and goes to sleep.

In the case, we see a change from a rule-based approach to a negotiation-based approach. The professionals, who brought Hans in, followed the rules. Since Hans was aggressive, action was taken, and he is brought to a safer environment. The professionals followed the rules as laid down in the law on coercive treatment in psychiatry. Although this action aimed to prevent harm, it is experienced by Hans as an infringement. The professionals involved did not try to understand Hans, he was regarded as dangerous. Yolande does not go along with this way of dealing with the situation. She does not agree with her colleagues who suppose that Hans is a candidate for seclusion, but tries to relate to him. She approaches Hans as a person, acknowledging that he will feel restricted by being tied to the bed. Although she is not totally sure how he will react, she hopes that he will become more relaxed once the ties are loosened. She addresses him as a person, shows she tries to understand him, and asks for his cooperation. Hans responds in a positive way, and the danger is diminished, not by restriction, but by attention and negotiation.

Moral case deliberation

In the case story, we see that the nurse does not follow the standard procedures, but tries to solve the problem in a new way. How can we foster such creative solutions in practice? Given that violence is threatening, it will not be easy for professionals to be flexible in applying the rules. The rules set certain standards which are experienced as given. The colleagues of Yolande assume that there is no other way then to put Hans in seclusion. If we want to change practice, we need specific interventions to make professionals aware that responsibility is more important than rules. One way to do this is to make them reflect on the moral aspects of problematic situations. In a mental health institution, we organized a series of meeting with professionals to reflect on issues related to coercion. These meetings had the format of Moral Case Deliberation (MCD) (Molewijk et al., 2008).

In MCD, a group of professionals discuss a case from one of the participants guided by a facilitator using a structured discussion method. The focus is on the moral questions and experiences of the participants. MCD is implemented in healthcare institutions through a series of meetings in which the participants learn to apply the method and gradually become more open towards one another and learn how to investigate their moral concerns. The following is an example of one of the meetings.

In one of the sessions, a case about preventive seclusion was discussed. A nurse from an acute emergency department submitted the case, concerning a young man who had been admitted to the ward for five days. On his fifth day, the nurse came back from holidays. During that day she and her female colleague decided to put the young man into the seclusion room in order to prevent aggressive escalations and to maintain the general safety on the ward. However, the nurse had a serious concern with respect to the moral justification of the decision to put the young man in the seclusion room.

During the moral deliberation session, which took 90 minutes and which was facilitated by an ethicist, the participants first paid attention to the factual aspects of the case and the background of her worry whether she had done the morally right thing. Through a first inquiry with respect to the case, the ethicist and the participants helped the nurse to formulate her core moral question which functioned as the specific starting-point for the collective moral inquiry: "Was it morally justified to put the man in the seclusion room at that time?" They reflected upon the concrete case through questioning and with respect for the nurse's and other's interpretation of the situation. Next, the participants discussed the existing views among the participants regarding the question whether the decision was morally justified. Various, sometimes opposite, justificatory arguments were made explicit and examined, and also the conceptual analysis of the detailed aspects of actually making a decision, and the morally right timing for this specific decision, were challenged.

The participants became aware that the decisive reason for the seclusion had not been the potential threat of the patient as such (which is the standard medical and legal criterion for seclusion and therefore often pops up at first as "the" argument), but the lack of good communication with the young man, the nurses' risk assessment with respect to the upcoming evening shift, and the lack of any relationship with the young man because of the nurse having been away on holiday. The situation was perceived as potentially dangerous, because there was little insight into the patient's possible reactions. Thus, the danger was not so much in the patient; it was the result of the specific staff situation and the (a lack of) interaction with the

patient. A better information transfer during changes of the shift and communication with the patient might have been an alternative to putting the patient in seclusion.

During the evaluation of this moral deliberation session, participants mentioned that they appreciated the fact that a colleague could openly doubt whether she did the right thing; they considered this as a professional attitude. Furthermore, they felt that the attitude of the ethicist and the specific codes of conduct related to the conversation method (i.e., a Socratic dialogue) gave enough security to examine each other's presuppositions in more depth. They learned that the process of making a decision is more complex and has more nuances then is often suggested. They appreciated that they had developed a new view on the role of danger and the relationship between communication and danger. As a result, they decided to be especially critical when justifications for using the seclusion room are brought up. They also decided to improve the staff composition with respect to the continuity of staff members who have already a relationship with the clients.

Finally, they also realized that making moral judgments is closely connected to the pre-understandings of the situation. They became aware of the fact that one single act can be interpreted in many different (or even opposite) ways. They also became aware that things and acts and words have no static universal meanings.

Conclusion

The standard ethical answer to violence is making rules which aim to protect individual rights (both of healthcare providers and healthcare receivers). Rules and rights provide important safety-nets in society. Yet, rules do not solve problems by themselves. They need to be interpreted by those who have to apply them. This requires capacity and experience. If rules are merely obeyed externally, interpersonal moral relationships are undermined. Therefore, professionals should be open, both to those patients (or colleagues) who appear to be dangerous, and to their own worries and doubts. This requires structural attention for reflection in healthcare practice. Moral Case Deliberation can help to create a climate in which professionals are fostered to reflect on difficult situations and supported in finding new ways of dealing with violence.

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Correspondence

Mr Guy A.M. Widdershoven
Department of Medical Humanities
EMGO Institute for Health and Care Research
VU University Medical Center Amsterdam
g.widdershoven@vumc.nl

Workplace violence - from taboo to agenda: Some sociological considerations

Keynote

Jon Adams

Abstract

While an emerging research programme has begun to chart and examine occupational and workplace violence in the health sector much of this work has focused upon identifying prevalence rates, capturing experiences of violence and developing an evidence base for implementing strategies of prevention and response. In complement to such important investigations and in line with multi-method, multi-disciplinary enquiry, social science can help provide significant insights regarding the cultural and social contexts of health sector violence and responses/strategies to such violence.

Drawing upon an extensive programme of research examining occupational violence in general practice/ family medicine in Australia, this talk outlines a selection of key social science insights gained from recent fieldwork experiences and data collection. In particular, the talk explores the significance of adopting and promoting a wider sociological research gaze as part of an applied health services research agenda. A number of examples are outlined including identification of a geographical schema for framing occupational violence in primary health care, examining the experiences and perspectives of a range of stakeholders, and exploration of wider professional culture in understanding reactions and responses to violence and subsequent strategies.

Correspondence

Mr Jon Adams
Head Discipline of Social Science
School of Public Health
University of Queensland
Australia
+61 404 933 790
j.adams@sph.uq.edu.au

A crime beyond belief: Serial health care murders

Keynote speech

Paula Lampe
Author, Assen, The Netherlands

Serial murder in the health sector has been identified in the literature as a phenomenon since the 1980's however there has been no systematic reform designed to reduce the risk of this serious and predictable form of violence. In 2006 an international team of experts published their research based on international data from criminal prosecutions of 90 healthcare providers who were charged with serial murder of patients in their care.

The number of health care workers charged with health care serial murder (HCSM) has increased in each of the past four decades, with more than four times as many such occurrences being reported worldwide during 2000-2009 than 1970-1979. Injection is the main method used by healthcare killers followed by suffocation, poisoning, and tampering with equipment. Prosecutions took place in 20 countries with 40% occurring in the United States. Nursing personnel comprise 86% of the healthcare providers prosecuted; physicians 12%; and 2% are allied health professionals. The number of patient deaths that resulted in a murder conviction exceeds 330 and the number of suspicious patient deaths attributed to the convicted caregivers is well over 2200. These numbers are disturbing and suggest that the health sector improve tracking patient deaths associated with presence of a specific healthcare provider. Hiring practices must shift away from protecting the healthcare worker's rights to protecting patients from employees who kill.

Keynote

During the keynote I will, in combination of a Power Point Presentation, present some background information about HCSM and discuss the research that so far has been done.

Workshop

In the workshop I will present a British TV documentary: Real Crime: Angel of Death, Colin Norris. From Producers/ Director: Kristin Hadland. Executive Producer: Andrew Sheldon. www.truenorth.tv was so kind to donate this documentary.

The documentary will focus on one of the biggest Health Care Serial Murderer ever Harold Shipman, a general practitioner who killed over 215 of his patients and was sentences to life imprisonment in 2000. In 2008 the British nurse Colin Norris was also convicted for life imprisonment for murdering four women patients and one attempted murder.

After the documentary presentation I will discuss why, so far, whistleblowers are always neglected. Participants will be invited to make recommendations for reducing the chance of dangerous healthcare providers harming patients.

Correspondence

Ms Paula Lampe
Author
Assen
The Netherlands
Holland
plampe@home.nl

Protecting from workplace violence - tools from the Massachusetts Nurses Association

Keynote speech

Evelyn I .Bain
Division of Health and Safety, Cranston, RI, USA

Abstract

With more than ten years of work dedicated Workplace Violence Prevention in a variety of healthcare settings, Massachusetts Nurses Association (MNA) members and staff have developed several useful tools that can be utilized by nurses, other healthcare workers, and their managers in any healthcare or other work setting. The MNA is pleased to share these materials with nurses across the world, through this 2010 conference. The materials are designed to be used for improving safety in the work environment for all healthcare workers, as well as increasing safety and improving health outcomes for patients. Please credit the source when using these materials.

The presentation will address:

- Problems of Workplace Violence in the USA
- MNA Workplace Violence Position Statement – A plan to protect nurses
- MNA Violence Assessment - Survey tool
- MNA Model Contract Language on Violence Prevention
- Suggested training activities
- Support for injured workers
- Addressing criminal aspects of violence in healthcare settings
- Program evaluation and modification
- MNA Violence Prevention success stories
- MNA Legislative initiatives and successes

Please note that the slide presentation available by contacting Evelyn I. Bain at eviebain77@gmail.com and that all MNA materials may be accessed through the website of the MNA at www.massnurses.org

Correspondence

Ms Evelyn I .Bain
M Ed, RN, COHN-S, FAAOHN
Consultant – Health and Safety
Formerly Associate Director, Coordinator, MNA Division of Health and Safety
77 Poppy Drive,
Cranston, RI,
02920, USA
+1 401 946 0801
eviebain77@gmail.com

Violence: Why? And how to control it?

Keynote speech

Albert van der Zeijden
Past chair International Alliance of Patients' Organizations (IAPO), Utrecht, The Netherlands

Abstract

When we speak about violence, heath care settings are not the first places coming into our mind as a common place for violence. Yet statistics show us that 72% of nurses do not feel safe from assault at work. Statistics strongly support the suggestion that violence in the health care sector is growing, however we do not know how reliable a comparison of current violence and violence some decades ago really is. Most probably there is a lot of under-reporting and it may be that due to the growing interest in the subject the reporting barrier is becoming more and more less a barrier than it may have been in the past. We could also question, whether, if the eagerness to report is growing, this is so for all forms of violence in the health sector, as there are:
- Violence of care-workers to care-workers
- Violence of care-workers to patients
- Violence of patients to care-workers.

In all cases violence is unacceptable. Violence is never solving any problem in the first place, but it is also undermining the goal to achieve patient-centered health care and the satisfaction of care-workers with there job. This makes it very likely that health-care workers will leave their position and that less people will be willing to join the workforce in a time that in many countries there is a growing lack of health-care workers.

The pattern of the situations in which violence occur will be different in different health care environments, like the surgery of a general practitioner, the different sections of (psychiatric) hospitals and nursing homes. Violence of care-workers to care workers will be more common in hospitals, whilst violence of care-workers to patients will probably be more common in nursing homes. Violence of patients to care workers can be found at all places in the health sector, but certainly not in abundance in nursing homes. In all situations it is important to know which sector related background factors are contributing to the atmosphere in which violence originates. Sound research is needed here to improve our efforts to prevent all people in the health sector of violence. We need to know more about the role and which role this is in provoking violence of potential determinators of violence, like there are:
- Stress at the shop floor
- The soundness of protocols
- The patient – health care worker relationship
- The hierarchical structure of the relationships between health care workers.

For the International Alliance of Patients' Organizations patient-centered health care includes a violence free work place for health care workers as well as a sector in which patients can find the best possible solution for their health problems. Violence is not the normal way of engagement between people in whatever setting, let alone in health care settings.
Prevention of violence in health care therefore should be a prime objective of cooperation between all stakeholders. Speaking about it is not enough, we need shared evidence based actions to make the health sector a violence free environment.

Correspondence

Mr Albert van der Zeijden
Past chair International Alliance of Patients' Organizations (IAPO)
Louise Kerlinghof 20
3571 TR Utrecht
The Netherlands
+31 30 271 89 51
avanderz@xs4all.nl

Chapter 2 - Awareness promotion, visibility, and public attention

EU-OSHA: Raising awareness and promoting solutions to violence at work

Paper

Timothy Tregenza, Zinta Podniece
European Agency for Safety and Health at Work, Bilbao, Spain

Introduction

The European Agency for Safety and Health at Work (EU-OSHA) is the main EU reference point for occupational safety and health information, collecting, evaluating, and disseminating information for all stakeholders in occupational safety and health (OSH). It works within the framework of the Community Strategy for Health and Safety at Work, 2007-2012 (Communication from the Commission to the Council and the European Parliament Improving quality and productivity at work: Community Strategy 2007-2012 on health and safety at work Brussels 2007 COM (2007) 62), which identifies violence at work as an emerging risk factor.

The situation in Europe

In 2009, EUROSTAT reported on the magnitude of (non-fatal) work-related illnesses and accidents and found that 8.6% of workers (in all sectors) experienced a work-related health problem in the last 12 months which corresponds to 20 million persons. The most commonly identified health problems were bone joint, muscle problems, stress, anxiety, or depression (EUROSTAT Statistics in focus 63/2009 2009). It has also been calculated that 167 000 deaths a year are attributable to work in the EU-27, of which 5% are caused by accidents or violence (EUROSTAT Statistics in focus 63/2009 2009).

The fourth working conditions survey by EUROFOUND noted that there has been an increase in the level of physical violence in the period 1995 – 2005 in the EU 15, and while neither sex, nor employment, nor contractual status appear to have a significant impact on exposure to violence, "white-collar" workers are somewhat more exposed than "blue-collar" workers. In the health and social work sector, exposure to violence at work is reported by over 15% of workers. Health care workers are eight times more likely to have experienced the threat of physical violence than workers in the manufacturing sector (EUROFOUND Fourth Working Conditions Survey ISBN 92-897-0974-X 2007).

European Survey of Enterprises on New and Emerging risks

In 2009, EU-OSHA ran the European Survey of Enterprises on New and Emerging Risks (ESENER, http://esener.eu). This survey asked how health and safety risks are managed at their workplace, with a particular focus on psychosocial risks; i.e. on phenomena such as work-related stress, violence and harassment. The purpose of the survey was to assist workplaces across Europe to deal more effectively with health and safety and to promote the health and well-being of employees. It provides policy makers with cross-nationally comparable information relevant for the design and implementation of new policies in this field.

The survey, which involved approximately 36,000 interviews and covered 31 countries (EU27 plus Croatia, Norway, Turkey, and Switzerland), interviewed managers and worker safety representatives in enterprises with more than 10 workers in both the public and private sectors to find out the real situation of safety and health management in Europe.

Preliminary results from the survey have been published (EU-OSHA ESENER – European Survey of Enterprises on New and Emerging Risks Luxembourg: Publications office of the European Union 2010 ISBN 978-92-9191-327-5), finding that:
- Formal occupational safety and health policies and risk assessments are more frequent in larger establishments but vary in frequency by country;
- Those that do not have safety and health policies say that this is either because they do not see the need, or that they do not have the expertise to put in place the policies;

- Employee involvement is a strong driver for addressing occupational safety and health information;
- Causes of sickness absences are only analysed by half of respondents; principally those in medium and large establishments and those in the health-care sector.

When considering psychosocial issues such as stress, violence, and bullying at work these are being identified as concerns. Management of these issues is more frequent in the health and social work sector but the southern European countries (except Spain) show less awareness and are less likely to take action to manage psychosocial risks. In 50% of all EU establishments, having to deal with difficult patients, pupils, etc. was identified as the main psychosocial risk factor.

The health and social care sector was the sector where most procedures on work-related violence were put in place, unsurprising given that it was the sector with the most concern on this topic. However, while violence or threat of violence was most identified as a concern, in nearly 60% of all such establishments, the number with procedures is just below 50%. In the sector, about 70% of workers were informed about (all) psychosocial risks and their effects on health and safety.

The reason establishments in the health-care sector took actions on psychosocial risk factors was primarily to fulfil legal obligations. Requests from employees were the second reason. Lack of resources (time, money, staff) and "the sensitivity of the issue" were the main reasons given for not taking action on these psychosocial risks in the sector. In all sectors, managers felt that knowledge was needed on how to design and implement preventive measures, how to include psychosocial issues in the risk assessments, and how to deal with issue such as violence.

While training and changes in work organisation are the main measures put in place to address psychosocial risks, only about half of respondents inform employees about psychosocial risks and their effect on health and safety. Given that actions on prevention of psychosocial risks demand considerable investment in staff resources and work organisation, this lack of information to employees is worrying. Lack of awareness and lack of resources were the reasons given for lack of action.

Many workplaces in the health and social-care sectors contain the risk factors identified by EU-OSHA for physical violence at work, being:
- Jobs where there are services offered directly to the public, working at night, or working with people in distress;
- Organisational aspects including inefficient internal procedures, inadequate training, lack of concern about workers' problems, and situations of organisational restructuring;
- Being exposed to persons who have difficulties in coping with stress, psychological or emotional instability, drug or alcohol abuse, or serious personality disorders (EU-OSHA European Risk Observatory Report 5 Expert forecast on emerging psychosocial risks related to occupational safety and health ISBN 978-92-9191-140-0 2007).

Prevention approaches

The European prevention approach can be simply described as protecting all workers from all hazards and risks. Article 137 of the Treaty establishing the European Community (Council Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31989L0391:en:HTML) states that "the Community shall support and complement the activities of the Member States in… [the] improvement in particular of the working environment to protect workers' health and safety".

The main legislative mechanism used to achieve this is the directive. Directives are legislative acts of the European Union that require Member States to achieve a particular result through legislative procedures at national level. In the case of occupational safety and health, the key directive, transposed into the legislation of all Member States is Council Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work (Council Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31989L0391:en:HTML), better known as the "framework" directive.

This Directive applies to all sectors of activity, both public and private, including industrial, agricultural, commercial, administrative, service, educational, cultural, and leisure, save only for where characteristics peculiar to certain specific public service activities, such as the armed forces or the police, or to certain specific activities in the civil protection services inevitably conflict with it. This means that the health and social care sectors are clearly covered by the directive.

In the directive, it is clearly stated that "the employer shall have a duty to ensure the safety and health of workers in every aspect related to the work" (Article 5, Council Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31989L0391:en:HTML).   Again, this is clear, and has been tested in court, that every aspect includes psychosocial risks such as violence, bullying, and work-related stress. Put very clearly, the exposure of workers to violence in the health care sector is a health and safety at work issue that is covered by legislation in every Member State of the European Union.

The framework directive then goes further. It sets out how the employer should protect workers from harm by laying out the European prevention approach. This approach is one of risk assessment followed by the application of a prevention hierarchy. This model (varying slightly for some specific hazards and risks such as chemicals or noise), is one that the European Agency for Safety and Health at Work is continually promoting to ensure that Europe's workplaces are protected. EU-OSHA puts "flesh on the bones" by giving practical guidance on how the legislative structure can be complied when dealing with different risks, different sectors, and different worker groups.

Risk assessment is the process of evaluating risks to workers' safety and health from workplace hazards considering what could cause harm, whether the hazards could be eliminated, and if not, what preventive or protective measures are, or should be, in place to control the risks. EU-OSHA promotes a "five-step" approach of:
• Identifying hazards and those at risk;
• Evaluating and prioritising risks;
• Deciding on preventive action;
• Taking action; and
• Monitoring and reviewing progress (EU-OSHA Risk assessment – the key to healthy workplaces 2008 TE-AE-08-081-EN).

So, in a simplified model, the employer would identify the threat of violence to staff working in casualty / the emergency room as the hazards, and that nursing, medical, cleaning, and administrative staff are at risk. The scale of the risk is assessed, for example it may be said that during night shift staff are at particular risk. The employer then decides on the action to take according to the hierarchy of control, puts in place the actions and then checks whether these actions are working.

The European Agency for Safety and Health at Work spends a considerable part of its budget raising awareness of workplace risks and of the practical ways in which they can be prevented. EU-OSHA has published general and specific guidance to help those carrying out risk assessments. This includes information on how to ensure a diverse workforce is protected (EU-OSHA Workforce diversity and risk assessment: Ensuring everyone is covered ISBN-13:978-92-9191-267-4 2009 and EU-OSHA Assessment, elimination and substantial reduction of occupational risks ISBN 978-92-9191-227-8 2009 and EU-OSHA Factsheet 24 Violence at work 2002 and EU-OSHA Factsheet 43 Including Gender Issues in Risk Assessment 2003), and how to carry out risk assessment in the health-care and home-care sectors (EU-OSHA E-Facts 35 Risk assessment for care workers 2008 http://osha.europa.eu/en/publications/e-facts/efact35 and E-Facts 46 Mental health promotion in the health care sector 2009 http://osha.europa.eu/en/publications/e-facts/46 and EU-OSHA E-Facts 18 Risk assessment in health care 2007 http://osha.europa.eu/en/publications/e-facts/efact18).

They include case studies on how work-related stress, caused primarily by sexual harassment and disrespect, was managed in hospital cleaners, and on how psychosocial risks were assessed in another. In addition, EU-OSHA has published information on how to carry out risk assessment for workers who carry out "home-care" that includes addressing the risks of violence, on mental health promotion in the health care sector, and on risk assessment in the health care sector.

The action the employer is required to take is set out in the "framework" directive, namely:
• Eliminate risk at source, if this is not possible then:
• Minimise or control risks, by:
  - Combating the risk at source
  - Adapting the work to the individual
  - Adapting to technical progress and changes in information
  - Substituting the dangerous with the non-dangerous / less dangerous
  - Applying organisational or collective measures
  - Personal protective measures as a last resort
• Giving appropriate instruction and information to workers.

Sadly, the elimination of the risk of violence is seldom possible for "front-line" staff as this would mean excluding the public from the health-care system so the focus is on measures to deal with preventing violence and mitigating the harm should it occur.

The following aspects should be considered in preventing violence:
- The design of the work environment, such as;
  - Improving lighting and visibility,
  - Public access to the workplace,
  - Reducing the number of tools or implements that could be used a weapons, and
  - Physical security measures (e.g. alarms);
- Administrative controls, such as;
  - A clear anti-violence policy,
  - Incident review procedures,
  - Appropriate staffing levels and shift patterns, and
  - Clearly addressing violence in the risk assessment;
- Behavioural strategies, such as;
  - Training in conflict resolution,
  - Training in recognition of early-warning signs of violence,
  - Developing a "zero-tolerance" approach, and
  - Team building; and
- Awareness raising, through;
  - Publicity campaigns for staff and public,
  - Dissemination of good practices,
  - Encouragement of positive attitudes, and
  - Liaison with enforcing authorities.

In addition to these measures required for preventing violent incidents, there is also a need for effective measures to be in place should an incident occur. This can reduce the harm to a worker, and should include:
- Not leaving the victim of violence alone in the aftermath of an incident;
- Involvement of senior management to ensure that the issue is perceived as being taken seriously;
- Providing psychological support to the victim, and also where necessary full legal, medical, and administrative support;
- Having a clear information dissemination policy to inform staff of events and how they are being managed; and
- The review of risk assessments to see if prevention procedures can be improved (EU-OSHA Prevention of violence to staff in the Education Sector 2003 TE-AE-03-047-EN-D and (EU-OSHA Violence at work 2002 TE-02-02-004-EN-D).

In addition to the material published by EU-OSHA that specifically relates to the risk assessment and safety management approaches, prevention in the health and social-care sectors, and on violence to work, the European Agency for Safety and Health at Work gives access to practical guidance from around the world through its database of case studies, risk assessment tools, and "OSH-Links" (for example, on risk management for nurses http://osha.europa.eu/data/case-studies/tackling-work-related-stress-2013-the-risk-management-approach-as-applied-among-nursing-staff-at-a-national-health-service-trusts/view and on assessing violence at work http://osha.europa.eu/data/case-studies/assessing-and-tackling-external-violence-at-work/view). The European Agency for Safety and Health at Work has case studies dating back to its campaign in 2002 on psychosocial risks in health care prevention (http://osha.europa.eu/Members/tregenza_osha_eu_int/programme-for-a-safer-hospital-safe-care/view and http://osha.europa.eu/Members/tregenza_osha_eu_int/the-management-of-violence-against-staff-in-the-healthcare-sector/view).

Conclusion

In the European Union, there is a clear legislative structure in place. In this structure, violence to workers in the health-care sector is an occupational risk and employers have a legal duty to protect workers exposed to such risks.

The European Agency for Safety and Health at Work, through its multilingual website (http://osha.europa.eu), provides guidance in support of this legislation for workers, employers, occupational safety and health professionals, policy makers, and researchers. Through its database of risk assessment tools, case studies and useful links, managers, workers, and occupational safety and health professionals can access existing guidance on the prevention of violence at work. Clearly, however, more information is needed and that which exists needs to be disseminated to workplaces and implemented.

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Correspondence

Mr Timothy Tregenza
European Agency for Safety and Health at Work
Gran Via 33
48009 Bilbao
Spain
+34 944 795 740
tregenza@osha.europa.eu

The hospital's role in the violence of patients

Poster

Monica Burgos, Tatiana Paravic
Universidad de Concepción, Concepción, Chile

Abstract

Patients/users appear susceptible to all kinds of stimuli and relationship arising within the hospital context where the care given is defined as impersonal and lacking privacy, posing the potential threat of becoming a victim to violent actions. Aiming at making a contribution to the improvement of health care given in hospitals, the importance of providing health care based on dignity and respect for the patients calls for a study of the violence issue that patients seem to perceive within health care contexts.

Correspondence

Mrs Monica Burgos
Universidad de Concepción
Roosvelt esquina Janequeo
Concepción
Chile
+56 41220 70 65
moniburgos@udec.cl

Social marketing campaign – A violence prevention pilot project

Paper

Chris Back, Tracy Larsen, Lara Acheson, Michael Sagar, Marty Lovick, Ana Rahmat, Judy Thompson
Occupational Health and Safety Agency for Healthcare in BC (OHSAH), Vancouver, Canada

Introduction

Workplace violence in healthcare is recognized as a significant issue in British Columbia (BC). In 2006, a provincial committee, focusing on preventing violence in healthcare, was created through policy discussions between the British Columbia Nurses' Union (BCNU) and the Health Employers' Association of BC (HEABC). The mandate of the Provincial Violence Prevention Steering Committee (PVPSC) was to examine and publish examples of best practice in violence prevention; establish a standardized curriculum on violence prevention and response; and develop a social marketing campaign to raise awareness in the general public on the issue of violence in healthcare workplaces.

Within BC, workers' compensation claims for violence-related injuries account for an average of 12% of all accepted claims in health care and 54% of violence-related claims from all industries [1]. While the effects of workplace violence on healthcare workers are well documented [2,3,4], underreporting of incidents of workplace violence makes it impossible to know the true extent of the problem [6,7]

Incidents of workplace violence, perpetrated by patients and their relatives are common [4,7]. Violence is defined by WorkSafeBC [8] as: "the attempted or actual exercise by a person, other than a worker, of any physical force so as to cause injury to a worker, and includes any threatening statement or behaviour which gives a worker reasonable cause to believe that he or she is at risk of injury". However there is not agreement by healthcare workers about what types of behaviors should be defined as violent [5] 5 and behaviors may be excused for compassionate reasons [5] or when they are related to an underlying clinical condition [6]. Incidents of workplace violence, especially verbal threats, are underreported because medical treatment was not required, lack of time to complete cumbersome reporting procedures [5] and a belief that reporting will not result in any action being taken. This, along with a widespread belief that the 'patient's needs always comes first', results in a culture where violence in healthcare is normalized and is accepted as 'part of the job [5,6].

In 2007, a social marketing campaign was developed and piloted in Campbell River, BC. The goal of the campaign was to raise public awareness of the seriousness of workplace violence in health care. A steering committee, with representatives from Employers, Unions, the Occupational Health and Safety Agency for Healthcare (OHSAH), and WorkSafeBC was struck to oversee the development, implementation, and evaluation of the creative multimedia campaign.

Methods

In July 2007, initial meetings took place to discuss a framework for developing a social marketing campaign aimed at raising awareness in the general population about workplace violence experienced by health care workers. Following these initial meetings, a project steering committee was struck which included representatives from the Vancouver Island Health Authority (VIHA), a number of health care unions, OHSAH and WorkSafeBC.

It was envisioned that the social marketing campaign would include television spots, newsprint ads and posters. Campaign effectiveness would be measured through a series of telephone questionnaires immediately before and after the campaign period, as well as a follow-up survey six months after the campaign ended. In order to move forward with the initiative and secure necessary funding, a number of issues had to be decided by the committee up front, including the target audience, the geographical area for the campaign, and message framing.

A decision was made that the campaign would be developed and implemented as a pilot as it would assist stakeholders in determining the possible benefits and challenges of this type of approach prior to attempting a province-wide campaign. However, based on the possibility that the campaign could be expanded at a future date, it was important to select a community where a broad spectrum of healthcare services are available along with a large enough population base to ensure proper evaluation. In addition, it was agreed that there needed to be organizational support to ensure front line staff involvement in the pilot, community support for the project and necessary media outlets to run the campaign.

Based on these criteria, it was agreed that the campaign pilot would be conducted in Campbell River, a community on northern Vancouver Island with a population of about 47,000 where acute, residential and home care services are provided. VIHA had experience conducting public surveys, related to a violence-prevention signage campaign, and was willing to provide in-kind resources to the project, such as staff time and travel costs. It was thought that there would be community support for the campaign as a well known 78 year old volunteer in the Campbell River hospital had been killed by a patient in 2006. In addition, the community had the requisite local television station and newspaper.

A total budget of $120,000 was provided by the Ministry of Health and WorkSafeBC. In December 2007, a project manager was hired, and the committee met with a focus group comprised of frontline staff from the acute, residential and home/community care sectors in Campbell River. Healthcare providers were asked to share their experiences and concerns around workplace violence, to identify attitudes and behaviors they would like to see change, the impact of violence on healthcare providers and what the message should be to the public and the best methods to get the message out to the community. As a result of the input from local healthcare workers, the decision was made to develop the campaign using the following messaging: "Care For Those Who Care For You", with the idea of juxtaposing images of ice hockey and healthcare.

The choice of ice hockey had several advantages. Primarily, it would be thought provoking, as most people would not associate violence in a care facility with that which takes place on an ice rink. The use of hockey would bridge a link between the occupational violence in sport with that faced by healthcare workers. Professional hockey players hold a near-iconic place in Canadian society, and depicting a local-born National Hockey League (NHL) player would give the campaign some instant visibility.

Three different television commercials, running 30 seconds each, were produced, along with newspaper ads (using a comparison with law enforcement) and an 11"x17" (28cm x 43cm) color poster. The videos and photos were all produced locally, using front line healthcare workers from Campbell River. All campaign materials were produced in a manner that would make them easily modifiable for use in other geographical regions or with other messages, should the pilot be expanded into a larger campaign.

There was significant involvement from the community in the development of the advertising materials, from the town's mayor, who helped the project obtain free ice time, and opened the doors to contacts who helped by providing actors and audience members for filming. A local company donated thousands of dollars worth of sporting goods. The hockey player featured prominently in the campaign is Carsen Germyn, who is from Campbell River, and at the time, was playing for the Calgary Flames of the NHL.

The social marketing campaign was launched on September 30, 2008 and ran through to the end of October 2008. The television ads were shown on local channels during the morning and evening news. The campaign bought enough airtime to run the 30 second commercials a total of 60 times in the morning and 20 times in the evening. The stations which broadcast the commercials are seen as far away as Victoria and Vancouver, cities with significantly greater populations than Campbell River. The newspaper ads were run in the local newspapers during the campaign, and the posters were distributed in key public areas throughout Campbell River.

Evaluation of the campaign's effectiveness included pre and post public telephone surveys. An external polling company was contracted to conduct the telephone surveys and provide the steering committee with summary reports. Residents of Campbell River were surveyed prior to the campaign to establish a baseline of their perceptions about workplace violence across six different sectors including healthcare. The community was also surveyed immediately following the campaign in November 2008 to gain a sense of how they responded to the campaign materials, and to discover what worked and what messages were heard. A final survey was done six months after the campaign had concluded (in April 2009) to assess long-term retention of the key messages and public awareness. For each of the public telephone surveys the polling company contacted members of the public in Campbell River until 1,000 people completed the survey, to ensure the results were statistically significant.

Results

Respondents of the baseline survey were asked to rate six different sectors (education, firefighters, healthcare, law enforcement, retail, and social services) on the basis of how significant an issue they felt workplace violence was for each. The top three occupations in which violence was felt to be a significant or very significant issue were, in order: law enforcement, social services, and healthcare. It is important to highlight that up to this point in the telephone survey, respondents were not aware of the healthcare sector focus of the survey.
Overall 70.4% of all respondents felt that on-the-job violence was a significant or very significant issue in healthcare. This is a very high awareness rate for a pre-advertising study, and was likely directly related to the earlier death of a hospital volunteer in Campbell River Hospital in 2006. When asked specifically about violence in the healthcare sector, more than one-half of respondents felt that they had a good (33.7%) or excellent (21.8%) understanding of the issue.

Respondents of the public telephone surveys completed both immediately after, and six-months after, the campaign indicated the same three occupations in which violence was felt to be a significant or very significant issue; however, healthcare moved up to the second position, ahead of social services. Law enforcement remained in the top position on both surveys. Seventy-four percent (73.8%) of all respondents of the immediate post-campaign survey felt that on-the-job violence was a significant or very significant issue in healthcare. This decreased slightly to 72.8% six-months post-campaign. Although this is not a significant increase from the pre-campaign survey, the healthcare sector was the only one out of the six industries to experience an increased perception of violence as a significant or very significant issue (the other five industries all experienced a decreased perception).

When asked specifically about violence in the healthcare sector, more than one-half of respondents in both of the post-campaign surveys felt that they had a good (38.2% immediately post; 39.0% six-months post) or excellent (27.8% immediately post; 23.0% six-months post) understanding of the issue. The change seen in both of the post-surveys is a statistically significant increase from the pre-campaign survey in self-rating of awareness of healthcare workplace violence.

An important part of the post-campaign surveys was the exploration of respondent awareness of the campaign multimedia. Over half (53.3%) of respondents immediately following the campaign recalled seeing campaign materials and 70% of these respondents felt the campaign was effective or very effective in creating awareness of workplace violence. Campaign material recall increased to 61.1% in the six-month survey; however, the effectiveness rating decreased to 60%. The newspaper ads were the most effective overall (cited by 76.2% of respondents who recalled seeing the campaign in the immediate post-survey and 62.4% of respondents who recalled seeing the campaign in the six-month post-survey).

Respondents of both post-campaign surveys, who recalled seeing the campaign materials, most frequently indicated the "Awareness of the seriousness of the problem" and that "Violence can come in many forms" as the key messages of the campaign.

Respondents of the six-month post-campaign survey were asked an additional question about whether or not they had noticed a change in awareness of violence in the healthcare sector among their co-workers, friends, or family members. Overall, just over half of survey respondents (51.3%) felt that there had been an increase in public awareness of on-the-job violence in healthcare since the campaign. Approximately three in ten respondents (32.3%) felt that people were somewhat more aware, and approximately two in ten (19.0%) felt that people were much more aware.
Survey results also revealed that males viewed workplace violence as less of an issue than females, and the most lasting effects of the campaign were seen in respondents 65 years of age or older.

The survey of healthcare workers in the Campbell River region indicated that the campaign increased the respondents' awareness and the public's awareness of violence as an issue in health care. When asked if the campaign improved staff to staff interactions, 26% or respondents agreed and 7% strongly agreed. When asked if the campaign improved interactions between staff and the public, 25% or respondents agreed and 5% strongly agreed.

Unintended Consequences and Lessons Learned

There were a couple of issues that resulted from the pilot project that were not anticipated at the outset. One was that occasionally the television ads ran adjacent to ads from private post-secondary schools who were promoting the profession of health care as a place to work. This was matched by a number of

comments from survey respondents that would put caring professions in a negative light. For example, respondents indicated that "Health care is a dangerous profession" and "I wouldn't want to be a nurse."

Another lesson learned was that the six month gap between the end of the campaign and the final telephone survey made doing a complementary follow-up campaign to build on messaging from the pilot impossible. Conducting a complete social marketing campaign that went beyond solely raising awareness would have lead to a more thorough examination of messages.

Conclusion

The telephone surveys completed after the campaign indicate that self-awareness of on-the-job violence increased in all age categories and the public's view of violence in healthcare increased relative to other industry sectors. In retrospect choosing a city which had a high profile violent incident was effective in generating community good-will, but also made it more difficult to increase awareness levels.

The materials developed for this campaign are continuing to be used by the project partners in web-based campaigns, as well as for education and training sessions. The commercials have been incorporated into BC's standardized curriculum on violence prevention in healthcare. Due to the economic downturn in 2009, funding was unavailable to expand the social marketing campaign provincially. The project partners are hoping that there will be a chance to develop other social marketing campaigns in the future, building on the experience gained from the pilot campaign that ran in Campbell River.

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Correspondence

Mr Chris Back
Occupational Health and Safety Agency for Healthcare in BC (OHSAH)
301-1195 West Broadway
V6H 3X5
Vancouver
Canada
+1 778 328 8012
chrisb@ohsah.bc.ca

Spite in white: Relational aggression among nurses

Paper

Cheryl Dellasega
Penn State University College of Medicine, Hershey, USA

Abstract

Recently, there has been much attention to the "mean girl" syndrome among adolescent girls, with humiliation, manipulation, and intimidation are tools of the trade, and as such, younger women use relationships to wage war against their peers. Technology has made it possible for relational aggression (RA) to communicate 24/7using text messages, blogs, and other social media to anonymously hurt another person.

The question now being asked is: "What about adult women? Don't they use RA too?" In the book Mean Girls Grown Up, Dozens of narratives suggest "yes," with grown up girls engaging in word wars in and out of the workplace, at the gym or PTA meeting, during community service group meetings, and even in churches or synagogues. There were specific groups where bitterness over RA created especially toxic environment, and one of them was nursing.

As a "caring" profession, it would seem that nurses would be immune to such behaviors, but a review of the literature shows they are not. Burnout, psychosomatic symptoms, depression, low job satisfaction and other negative consequences have all been linked to job stress if not specifically to RA. A sample of 52 emails to the author of an article on bullying among nurses by underscores these findings:

"I manage two units and see this behavior frequently. I have had a speaker come in and talk about horizontal workplace violence, but to address it for what it is 'bullying' I think makes a very strong point. In fact I have to discipline a nurse today for her bully behavior that caused disruption on the unit recently…I am a fairly new manager and one unit in particular has been very aggressive with a long history of bullying among each other and other units, they have never had their poor behavior formally addressed before…"

"Bravo! …Thank you for covering this topic so beautifully. It's my perception that this horizontal violence among nursing is a longstanding, yet unspoken sin. We also seem to underestimate the impact of this problem".

"I just read your article and I found it very interesting. There were different ways to bully that I didn't know and now, I could identify those behaviors and I found myself being sometimes bullying others without knowing it. Thanks to your article, I will try to do better and to be careful to not hurting other people with whom I am working with…"

"I have witnessed this behavior in nursing at all levels of practice and in every specialty area. As a nursing instructor I was so appalled by the behaviors of students to each other that I implemented an activity for seniors in our new curriculum and it has been very therapeutic to many as they have verbalized how they have been personally affected".

Unfortunately, unlike other professions, nurses cannot always turn to traditional stress management techniques for relief. They work in a high stress environment where they are in constant close contact with their coworkers cannot leave to have a pleasant lunch off site or take a leisurely walk.

Awareness is the beginning of change and self growth, and in this regard nurses are no different than others. However, this study will provide valuable information as well as the development of an instrument that will enable researchers and practitioners to make nursing a no-way RA profession.

Correspondence

Mrs Cheryl Dellasega
Penn State University College of Medicine
500 University Drive
17033-0850
Hershey
United States
+1 717 531 8778
cdellasega@psu.edu

Workplace abuse against nurses in hospitals in Iran

Poster

Mahnaz Shoghi Ghazanfar Mirzabeigi, Sedighe Salemi, Mahnaz Sanjari, Shiva Heidari Marzie Shirazi
School of nursing & Midwifery, Islamic Azad University, Karaj Branch, Karaj, Iran

Abstract

Background

The rising rate of doing behavioral violence to people working in health-care centers is a major problem for nurses' population.

Aim

This study was run with the aim of ascertaining how much nurses working in hospitals all over the country are under verbal violence and finding out its relation with some individual and environmental factors.

Method

This study is a descriptive cross-sectional one which was run with 1317 nurses as the participants in hospitals all over the country. Data collection was done through self-report questionnaire.

Results

87.4% of nurses experienced verbal violence at least once in their working surroundings during the last six months. Most of the verbal violence (64.4%) was done by patients' relatives (44.2%) between 7:30 am to 14:30 pm in the patient's room(48.3%). Results show that only 35.9% of verbal violence was reported by nurses. Investigating the frequency of verbal violence, the results of correlational analysis show that there is a significant relationship between verbal violence and variables such as age (p=0.009), sex (p=0.001), job experience (p=0.007), work hours (p=0.001) and job rank (p=0.048).

Discussion

Since lots of violence happens and the risk factors were investigated, more attention must be paid to this issue and the necessary steps must be taken in this regard. The findings of this study can be helpful to reduce, prevent and control the violence to nurses.

Educational goals
1. To investigate the frequency and types of abuse reported by Iranian nurses.
2. To describe the nature of perpetrators, the frequency of occurrence, and the location of abuse reported by Iranian nurses.
3. To describe how victims obtained help, the frequency of reports from abused nurses, and the number of times when harm was not reported.
4. To investigate the frequency of verbal abuse in relation to age, sex, job experience and position.

Correspondence

Mrs Mahnaz Shoghi
Senior Lecturer
School of nursing & Midwifery
Islamic Azad University, Karaj Branch
Shahid Moazen
98261
Karaj
Iran
+98 418 25 76
mahnaz.shoghi@kiau.ac.ir

Opening a dialogue on nursing student abuse: Disrupting the cycle of violence in nursing education

Paper

Pat Bradley, Alix McGregor
York University, Toronto, Canada

Abstract

International professional nursing associations' position statements on "zero tolerance" for violence in nursing have been ineffective in reducing abuse, aggression and incivility in clinical and academic settings. Rather, violence in health sector workplaces is known to be on the rise (MacIntosh, 2005) while nursing students' experience with abuse has remained relatively invisible in the literature. That nurses and nurse educators, whose caring profession embraces health promotion, continue to engage in abusive or uncivil behaviours is paradoxical and problematic. Drawing upon the literature and nursing students' reported lived experiences, this presentation challenges the notion that uncivil or abusive behaviours in academic and clinical settings are simply "just part of learning the profession". This presentation will provide a context for the experience of nursing students as they move through the experience of learning to be a caring professional. The primary intent of this presentation is threefold: 1) to open authentic dialogue on the nature, prevalence, and consequences of nursing student abuse, exploring contributions nursing faculty may be making to escalating cycles of incivility towards one another; 2) to challenge acceptance of the normalization of abuse within the nursing profession; and 3) to advance action-oriented strategies which acknowledge and address abusive educational practices which undermine teaching-learning environments, create unhealthy workplaces, and cause some nursing students to consider leaving the nursing profession.

Learning-working environments are known to reproduce and support "disempowering" Daiski (2004) professional relationships. During this interactive presentation, a dialogue exploring innovative strategies to begin healing our learning-working environments through connected student-teacher relationships will be facilitated. The presentation will create an open dialogue on managing abuse constructively at individual, curricular, and institutional levels, as nurse educators are positioned to play a significant role in reducing nursing student abuse thereby promoting healthier work environments in clinical and academic settings.

Educational goals
1. To describe the context of abuse in nursing education.
2. To identify individual, curricular, and institutional strategies to promote safe learning environments in nursing education.

Correspondence

Mrs Pat Bradley
York University
4700 Keele St.
M3J 1P3
Toronto
Canada
4167362100 x 33182
bradleyp@yorku.ca

Effectiveness of intimate partner violence prevention education conducted with female university students

Paper

Mika Hasegawa, Junko Kitade, Hiromi Yonezawa, Daisuke Higashi, Yasutoshi Nekoda
University of Fukui, Fukui-ken, Japan

Introduction

In 2008, the Cabinet of the Prime Minister conducted a survey that targeted a national sample of 5,000 men and women[1] in Japan. Of those respondents who stated that they "had (have) a romantic partner" during their teenage years or in their 20s, 7.7% of women and 2.9% of men reported experiencing physical force from their partner during their time of involvement. Further, "harassment and threats resulting in strong fear" were experienced by 7.8% of women and 3.1% of men. Finally, instances of "being forced to engage in sexual activities" were reported by 4.8% of women and 0.8% of men. The findings demonstrate the importance of measures for the prevention of violence for age groups with a higher proportion of people involved in romantic relationships. Additionally, the high percentage of women who experienced violence indicates that assistance in protecting against women becoming victims of violence is of special importance.

Promotion of health education on violence prevention is crucial as the first prevention measure on violence between partners. Education programs of the United States and Europe have served as pioneers in the development of preventive measures against violence. These programs target increasing understanding of violence[2], improving attitudes of violent behavior [3, 4], increasing appropriate help-seeking behavior[5], and reducing experiences of violence[6], all of which emphasize the need for youth intervention. However, differences in culture and value systems between Japan and other countries limit the application of foreign education programs, thus creating a pressing need for the development of a program befitting Japanese culture.

In the present study, an education program was developed for preventing intimate partner violence (henceforth, the Education Program) with female university students. A quasi-experimental design was used, employing the Education Program targeting female nursing students of two universities during a 3-month period. This report presents the analysis results and discusses the implications of the outcome for the intervention and comparison groups.

Method

1. Survey Participants
The intervention group consisted of 114 female students majoring in nursing at University A. The comparison group consisted of 90 female students majoring in nursing at University B. Thus the total number of participants was 204 (aged 18-22 years).

2. Education Program
The topics of the Education Program were: 1) accurate knowledge of violence, 2) major theories about violence[7-9], 3) the health impact of violence, 4) coping behaviors for violence[10], and 5) community support systems. These topics were covered over 180 minutes in a lecture format (with a portion of group work).

3. Survey Method
For the intervention group, the Education Program was conducted as part of their regular classroom lectures. Self-reported anonymous questionnaires were completed in a group setting prior to the start of the lecture (baseline), one month later, and three months later. The survey asked questions about the respondents' Knowledge, Attitudes, and Behavioral Intensions regarding violence. The questionnaires were collected immediately after completion. The timing, content, and method of administering the survey

to the comparison group were the same as that for the intervention group, and the survey was conducted by the same investigators.

4. Survey questions
Items about violence for Knowledge, Attitudes, and Behavioral Intentions were created based on research by Jaffe[3], Krajewski[4], and Women's Habitat[10]. There were 20 true and false items for Knowledge. The 12 items for Attitude and 15 items for Behavioral Intentions were rated on a five-point scale ("Strongly agree," "Agree," "Neither agree nor disagree," "Disagree," and "Strongly disagree"). To respond to items for Behavioral Intentions, the participants were asked to imagine two situations: one where they are using violence against their partners, and the other where they are the victims of violence by their partners.

5. Analyses
Item responses were grouped into two categories. For Knowledge, Attitudes, and Behavioral Intentions, responses of "Strongly agree" and "Agree" ("Neither agree nor disagree," "Disagree" and "Strongly disagree") were placed in the "Positive attitude" ("Negative attitude") category. A t test for continuous variables and a Chi-square test for categorical variables were used to compare the comparison and intervention groups at the baseline period. Alpha for statistical significance was set at .05. Cochran's Q test was used to test the proportion differences in the comparison and intervention groups at each of three time periods, namely, baseline, 1-month post intervention, and 3-months post intervention. When the Q test was significant, the McNemar test was used to test the differences in proportions at two matched time periods, and alpha was set at .0167 based on the Bonferroni method.

Results

1. Demographic characteristics of participants at baseline
Out of 204 participants, 175 individuals completed the study. Data from 94 individuals in the intervention group and 81 in the comparison group were analyzed. The mean age of the intervention group was 19.3 (SD = 1.2) and was 19.3 (SD = 0.8) for the comparison group. The presence of having an intimate partner was reported by 31.9% of those in the intervention group and by 44.4% of those in the comparison group. There were no significant differences between the groups regarding age and presence of a partner.

2. Knowledge, Attitudes, and Behavioral Intentions regarding violence at baseline
For knowledge of violence between partners, the proportion of participants who answered correctly for both groups fell below 70% on the following items: "A person is trying to control his/her partner when he/she abuses the partner" (53.2% of the intervention group, 44.4% of the comparison group); "Women abuse men as much as men abuse women" (55.3% intervention, 55.6% comparison); "Jealousy is an expression of love toward one's partner" (30.9% intervention, 19.8% comparison); "Alcohol/drugs and mental illness are causes of abuse" (12.8% intervention, 8.6% comparison); and "Men who abuse their partners are incapable of controlling their emotions well" (3.2% intervention, 2.5% comparison).

Regarding Attitude toward violence between partners, items for which less than 70% of participants of both groups showed a "Positive attitude" were, "There is no excuse for slapping one's partner, except in self-defence" (63.8% of the intervention group, 63.0% of the comparison group) and "Teenagers are easily provoked and sometimes cannot stop hitting" (41.5% intervention, 18.5% comparison).

On Behavioral Intentions for hypothetical situations in which respondents use violence against their partner, less than 70% of participants in both groups showed a "Positive attitude" on the following items: "I will remind myself that the use of violence was my choice" (55.1% of the intervention group, 60.0% of the comparison group); "I will look up information on violence" (41.6% intervention, 37.3% comparison); and "I will contact a counsellor or support group" (40.4% intervention, 37.3% comparison). In presupposed situations where respondents are the victims of violence by their partners, less than 70% of the participants showed a "Positive attitude" for all six items. The item that had the lowest proportion of participants in both groups responding with a "Positive attitude" was "Saying aloud positive thoughts to regain confidence" (38.2% intervention, 37.3% comparison).

3. Changes at baseline, 1-month post-intervention, and 3-months post-intervention
Participants' Knowledge, Attitudes, and Behavioral Intentions regarding violence at the three time periods were compared. The correct response rate for Knowledge significantly improved for nine items in the intervention group and for two items in the comparison group. Furthermore, in the intervention group, there were significant improvements on eight items from baseline to 1-month post-intervention, and from baseline to 3-months post-intervention.

There were significant differences in "Positive attitude" on four items for the intervention group and on one item for the comparison group. Among the items, significant improvements were noted for three items for the intervention group.

On Behavioral Intentions for hypothetical situations in which respondents used violence against partners, "Positive attitude" on all nine items significantly improved in the intervention group. On seven items, there were significant improvements from baseline to 1-month post-intervention and from baseline to 3-months post-intervention. For the items that had yielded a significant difference in the comparison group, there was a significant decline. In Behavioral Intentions for hypothetical situations in which respondents imagined themselves as victims of partner violence, there was a significant improvement on all six items for the intervention group, and of these, five items showed a significant improvement from baseline to 1-month post-intervention and from baseline to 3-months post-intervention. There was no significant difference observed in the comparison group.

Discussion

1. Characteristics of participants
The presence of having an intimate partner was reported by 31.9% of the intervention group and 44.4% of the comparison group. This is consistent with the results of a national survey on sexual behaviors among youth reporting the presence of a partner for 32.5% of 19 year olds and 40.2% of 20 year olds[11]. Thus, the current sample was representative of the general population in terms of the existence of a romantic relationship.

2. Changes in Knowledge, Attitude, and Behavioral Intentions over the 3-month period
1) Knowledge of violence: The correct response rates for nine of the 20 items significantly improved in the intervention group, indicating a level of effectiveness for increasing knowledge with the Education Program. In particular, marked improvements were noted on items that were central to the information provided by the Education Program, on topics such as victims' feelings as well as power and control. However, it is possible that, in addition to the direct effects of the Education Program, the questionnaire administered at 1-month and 3-months post-intervention resulted in repetitive learning for retaining knowledge about violence. Therefore, instead of a one-time intervention, providing several learning opportunities may be more effective in maintaining the acquired knowledge.

2) Attitude toward violence: The proportion of those demonstrating a "Positive attitude" in the intervention group significantly improved on three out of 12 items regarding attitude toward violence. The significant improvements noted on only three items may be because there were 10 items for which more than 70% of the participants already showed a "Positive attitude" at baseline.

3) Behavioral Intentions concerning the use of violence: In both hypothetical situations in which respondents are perpetrating violence and receiving violence, Behavioral Intentions significantly improved for items in the intervention group. Furthermore, items for which less than 70% of the participants showed a "Positive attitude" decreased from 12 items at baseline, six at 1-month post-intervention, and five items at 3-months post-intervention. The results suggest that the Education Program was effective especially for improving Behavioral Intentions concerning violence.

3. Areas for Improvement in the Education Program
1) Knowledge of violence between partners: We will discuss the implications of two items for which a low proportion of the intervention and comparison groups had correct responses, and for which the intervention group showed no significant improvement after program implementation.

Regarding the item "Women abuse men as much as men abuse women," the Education Program covered the existence of violence inflicted by women against men, in addition to violence by men against women, to provide participants with accurate information about inter-gender violence. However, this may have resulted in emphasizing violence by women against men, thereby obscuring what is actually true about violence between the genders. Future programs should not only show numerical data on violence by men against women and by women against men, but also include that being a woman is a risk factor in becoming a victim of violence.

"Men who are abusive are incapable of controlling their emotions well" reflects knowledge of why some individuals use violence. Although the conceptualization of "power and control" as reasons for violence was a central part of the Education Program, there are diverse perspectives on the motivation to use violence. For example, Nakamura[12] states that "self-displayed violence" is employed to reduce one's anger, whereas "instrumental violence" is used to modify the behavior of others. The Educational Program

did not mention the relationship between emotional control and violence. Future educational programs should incorporate topics of control and emotion, such as "self-displaying violence."

2) Attitude toward violence between partners: "Teenagers are easily provoked and sometimes cannot stop hitting" is another item for which there was a low proportion of respondents in both groups who answered correctly, and for which the intervention group showed no significant improvement after intervention. Regarding violence among teenagers, Matsubara[13] states that educational, family, and developmental issues contribute to bullying and violence in children, and that there is no one single cause for violence. The Educational Program did not consider developmental characteristics of teenagers, nor provide essential background information on education problems such as excessive competition over school entrance. Future education programs should be revised so that teenagers, who are the target population of violence protection efforts, are able to reflect on the relationship between violence and themselves, with consideration of their own educational situations and developmental characteristics.

Acknowledgments

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Correspondence

Mrs Mika Hasegawa
University of Fukui
23-3, Matsuokashimoaizuki,
910-1193
Eiheiji-cho, Yoshida-Gun
Fukui-ken
Japan
+81-776-61-8566
mikah@u-fukui.ac.jp

Chapter 3 - Environmental and specific health care setting considerations including urban and rural

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

Paper

Desley Hegney, Anthony Tuckett, Deborah Parker, Robert Eley
National University of Singapore, Singapore

Abstract

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

Educational goals
1. To increase awareness of local environmental factors.
2. To examine policies and their effectiveness.

Correspondence

Mrs Desley Hegney
National University of Singapore
Block E3A, Level 3, Engineering Drive 1,
117574
Singapore
+65 65163109
nurdgh@nus.edu.sg

Rural nurses' perceptions and training needs related to intimate partner violence

Paper

Tracy Evanson
University of North Dakota, College of Nursing, Grand Forks, North Dakota, USA

Intimate partner violence (IPV) has been described as a public health epidemic, resulting in more than billion in health care costs each year in the United States (U.S.) Nurses are often the first providers who interact with victims of IPV. This is particularly true in rural areas where nurses may be one of the only health care providers in the community, but research indicates that rural nurses are not well prepared to screen women and provide assistance in cases of IPV. The objectives of this study were to describe rural U.S. nurses' perceptions of IPV in their practice and in their communities, and to determine the best strategies to enhance rural nurses with the skills needed to effectively identify and assist victims of IPV. The study was descriptive qualitative in its approach, utilizing focus groups and individual semi-structured interviews with rural registered nurses as the data collection method. Registered nurses from two different states, repre senting more than 20 rural communities (defined as less than 2,500 population, participated in the study. Preliminary findings will be presented in this poster. The findings have significant relevance, in that there is currently little known about health care provider practices in relation to IPV in rural areas. Additionally, the findings will provide guidance for designing and delivering future IPV training of health care providers in rural areas.

Educational goals
To describe the perceptions of rural nurses in relation to IPV
To describe IPV training priorities for rural nurses

Correspondence

Mrs Tracy Evanson
University of North Dakota, College of Nursing
430 Oxford St., Stop 9025
58202
Grand Forks, North Dakota
USA
+1 701 777 4559
tracyevanson@mail.und.edu

Chapter 4 - The impact of violence including psychological, professional, ethical, economic, financial, legal, social, and political issues

Work place violence against psychiatric health care staff in Mansoura, Egypt

Paper

Abdel-Hady, Ali Ali El-Hawary, Mohamed Shoada
Faculty of Medicine, Mansoura University, Mansoura, Egypt

Abstract

Background:
Work place violence against psychiatry staff is a frequent occupational health hazard.
Objectives: to determine the extent of the work place violence against psychiatric health care providers and its risk factors compared to working staff in internal medicine department in Mansoura, Egypt.
Methods: A comparative cross-sectional study was carried out on 93 health care staff in psychiatric departments in Mansoura University Hospital and Mansoura General Hospital and 96 health care staff in internal medicine department in Mansoura University Hospital during the year 2008. Data were collected through an anonymous self-administered questionnaire. The questionnaire covered demographic characteristics, job satisfaction and violent incident.

Results:
More than 80% and 23% of workers in psychiatric and internal medicine departments reported exposure to one or more violent event during the past year with a mean of 5.9 and 2.0, respectively. Incidence of violence increases significantly among younger age groups, among nurses and with shorter duration of work. The most frequent contributing factors for violence were patients' dissatisfaction towards treatment, overcrowding, inadequate staff and lack of security. The majority of violent events occurred during visiting time and at evening shift. The most frequent consequences of violence as reported by victims were anger, irritability and anxiety. The assailants are mostly males, less than 40 years old, patients' relatives, patients themselves and were of low educational status.

Conclusion:
Work place violence against psychiatric health care staff is more frequent than those working in internal medicine department. Improvement of work circumstances e.g. providing more experienced staff, adequate treatment of psychiatric patients and avoiding overcrowding, will contribute to decreased risk of violence against psychiatric staff. There is a need for staff training to enhance team-building, improve communications, and encouraging report.

Introduction

Workplace violence is increasingly being recognized as a serious occupational hazard in the medical fields[1,2]. Many studies reported that violence against mental health service personnel is a serious workplace problem and one that appears to be increasing[3-5]. It has its origin in a number of individual and environmental factors[6-9]. Workplace violence is any act in which a person is abused, threatened, intimidated or assaulted in his or her employment. It includes threatening behavior, verbal threats, harassment, verbal abuse and physical attack[10]. Violence can trigger a range of physical and emotional outcomes in the victims[6-8].

Violence is not only an occupational health issue but also may have significant implications for quality of care provided and the decision by health workers to leave the health care profession. This can result in reduction in health services available to general population and an increase in health costs[11,12].

To the best authors' knowledge there is no published research on the problem of workplace violence in the health sector in Egypt. Furthermore, there is no formal acknowledgement of its existence. This study aims to determine the extent of the work place violence against psychiatric health care providers compared to workers in internal medicine department in Mansoura, Egypt. Also we explored the type of violence, its risk factors, its impact on the victim and nature of the perpetrator.

Subjects and Methods

The present study was conducted on all health care staff (doctors, nurses, social workers and psychologists) in psychiatric departments in Mansoura University Hospitals and Mansoura General Hospital during the period from January 2008 to March 2008. The total staff was 97 (45 doctors, 31 nurses and 21 social workers and psychologists). The response rate was 95.8%. A comparative group of 96 subjects was selected from approximately 200 personnel working in the department of internal medicine in Mansoura University Hospitals through a systematic random sample. Data were collected through an anonymous self-administered questionnaire covering the demographic characteristics including age, sex, residence, marital status, qualification, duration of job; job satisfaction (whether satisfied or not) and violent incident. Details were obtained about whether the personnel were exposed to workplace violence during the past year. If exposed what is the type of violence e.g. verbal, threatened, physical, number of events, effect of violence on individuals, as well as the characteristics of the violent person. All workers gave a verbal consent before completing the questionnaire as there is no research ethics committee in our institution.

Data were analyzed using SPSS (Statistical Package for Social Sciences) version 15. Quantitative variables were presented as mean ± standard deviation and Student's t test was used for comparison between groups. Categorical variables were presented as number and percent and Chi-square test was used for group comparison. $P \leq 0.05$ was considered significant.

Results

Both groups were matched regarding age, sex, residence, marital status, qualification, job duration and job satisfaction (Table 1). Table 2 shows that more than 80% and 23% of workers in psychiatric and internal medicine departments reported exposure to one or more violent event during the past year with a mean of 5.9 and 2.0, respectively. Among worker in psychiatry departments, incidence of violence increased significantly among younger age groups, nurses and workers with short work duration (Table 3).

Table 1: Comparison between the groups of health care personnel

		Specialty		Significance test
		Psychiatry No (%)	Internal Medicine No (%)	
Total		93 (100)	96 (100)	
Age (years):	<30	28 (30.1)	24 (25.0)	$c_2 = 2.2$
	30-	42 (45.2)	39 (40.6)	P = 0.3
	40+	23 (24.7)	33 (34.4)	
Sex:	Male	40 (43.0)	35 (36.5)	$c_2 = 0.8$
	Female	53 (57.0)	61 (63.5)	P = 0.4
Residence:	Urban	49 (52.7)	63 (65.6)	$c_2 = 3.3$
	Rural	44 (47.3)	33 (34.4)	P = 0.07
Marital status:	Never married	20 (21.5)	13 (13.5)	$c_2 = 2.1$
	Ever married	73 (78.5)	83 (86.5)	P = 0.15
Occupation:	Nurse	31 (33.3)	37 (38.5)	$c_2 = 5.1$
	Doctor	41 (44.1)	49 (51.0)	P = 0.08
	Social worker / psychologist	21 (22.6)	10 (10.7)	
Qualification:	Diploma	31 (33.3)	37 (38.5)	$c_2 = 0.6$
	Bachelor	33 (35.5)	31 (32.3)	P = 0.8
	Postgraduade	29 (31.2)	28 (29.2)	
Job duration:	<10 y	35 (37.6)	39 (40.6)	$c_2 = 0.2$
	10 & more	58 (62.4)	57 (59.4)	P = 0.7
Job satisfaction:	No	36 (38.7)	36 (37.5)	$c_2 = 0.03$
	Yes	57 (61.3)	60 (62.5)	P = 0.9

Table 2: Types and number of attacks of work place violence against the studied groups

Type of violence	Speciality		Significance test
	Psychiatry No (%)	Internal Medicine No (%)	
Any type of violence	75 (80.6)	45 (23.2)	c2 = 23.1, P ≤ 0.001
Verbal	75 (80.6)	45 (23.2)	c2 = 23.1, P ≤ 0.001
Threat	54 (58.1)	8 (8.3)	c2 = 33.1, P ≤ 0.001
Physical *	27 (29.0)	7 (7.3)	c2 = 5.8, P = 0.016
Number of violent attacks	X ± SD	X ± SD	
Any type of violence	5.9±1.1	2.0±0.8	t=20.4, P ≤ 0.001
Verbal	4.0±1.2	1.6±0.7	t=11.7, P ≤ 0.001
Threat	1.7±0.7	1.1±0.4	t=2.1, P = 0.04
Physical	1.7±0.5	1.1±0.4	t=3.1, P = 0.004

Categories are not mutually exclusive
*Physical violence includes grabbing, slapping, pushing, kicking

Table 3: Predictors of violence in each group of health care personnel

		Speciality (number & % of exposed to violence)			
		Psychiatry		Internal Medicine	
		No (%)	Significance test	No (%)	Significance test
Overall		75 (80.6)		45 (23.2)	
Age:	<30 y	25 (89.3)	c2 = 7.8	10 (41.7)	c2 = 1.2
	30-	36 (85.7)	P = 0.02	17 (17.7)	P = 0.5
	40+	14 (60.9)		18 (18.8)	
Sex:	Male	34 (85.0)	c2 = 0.9	18 (51.4)	c2 = 0.5
	Female	41 (77.4)	P= 0.4	27 (44.3)	P = 0.13
Residence:	Urban	38 (77.6)	c2 = 0.6	26 (41.3)	c2 = 2.3
	Rural	37 (84.1)	P = 0.4	19 (57.6)	P = 0.13
Marital status:					
	Never married	18 (90.0)	c2 = 1.4	5 (38.5)	c2 = 0.4
	Ever married	57 (78.1)	P = 0.2	40 (48.2)	P = 0.5
Occupation:	Nurse	29 (93.5)	c2 =19.3	24 (64.9)	c2 = 8.8
	Doctor	36 (87.8)	P ≤ 0.001	16 (32.7)	P = 0.012
	Social worker / psychologist	10 (47.1)		5 (50.0)	
Job duration:	<10 y	34 (97.1)	c2 = 9.8	18 (18.8)	c2 = 0.01
	10 y+	41 (70.7)	P = 0.002	27 (28.1)	P = 0.9
Job satisfaction:	No	32 (88.9)	c2 = 2.6	15 (41.7)	c2 = 0.6
	Yes	43 (75.4)	P = 0.11	30 (50.0)	P = 0.4

Table 4 reveals that the most frequent contributing factors for violence were patients' dissatisfaction with treatment, overcrowding, inadequate staff and lack of security. The majority of violent events occurred during visiting time and at evening shift. The most frequent consequences of violence as reported by the victims were anger, irritability and anxiety. Most of the assailants were males of less than 40 years old, patients' relatives, patients themselves and of low educational status. Only 21.7% of victims reported the event of violence to the hospital authority (Table 5).

Table 4: Contributing factors and consequences to violence among 120 health care personnel exposed to violence

Contributing factors	No (%)
Factors related to Staff	
Insufficient staff	97 (80.8)
Lack of training & experience to deal with violence	88 (73.3)
Factors related to patients	
Dissatisfaction with treamtent	105 (87.5)
Early release from hospital	50 (41.7)
Alcoholism	23 (19.2)
Factors related to Work place	
Inadequate security *	95 (79.2)
Uncomfortable waiting place	59 (49.2)
Long waiting time	42 (35.0)
Physical environment	
Noise	30 (25.0)
Extreme temperature	8 (6.7)
Indadequate light	4 (3.3)
Overcrowding	104 (86.7)
Bad housekeeping	15 (12.5)
Work in isolated places	36 (30.0)
Circumstances	
Meal time	3 (2.5)
Visiting time	95 (79.2)
Working shift	
Morning	32 (26.6)
Evening	93 (77.5)
Night	55 (45.8)
Consequences	
Psychological effect:	
Irritability	83 (69.2)
Fear	46 (38.3)
Anger	86 (71.7)
Anxiety	65 (54.2)
Depression	40 (33.3)
Pain / scratches / contusion	5 (4.2)
Others (work time loss, absence from work, request for sick leave)	5 (4.2)

Categories are not mutually exclusive
*No camera, no alarm and few security personnel

Table 5: Profile of assailants, and report of violent events

Profile of assailant		No (%)
Sex:	Male	581 (92.5)
	Female	39 (7.5)
Age:	Less than 20 years	134 (25.8)
	20-	317 (60.9)
	40 and more	26 (5.0)
	Unknown	43 (8.3)
Nature:	Patient	126 (24.1)
	Patient's relative	347 (66.7)
	Colleague	47 (9.2)
Education:	Illiterate	126 (24.2)
	Less than secondary	173 (33.3)
	Secondary	48 (9.2)
	Above secondary	17 (3.3)
	Unknown	156 (30.0)
Report of violent incident		113 (21.7)

Discussion

For the staff of psychiatric units, violent behavior is a growing problem in their environment [13, 14]. Assaults on staff in psychiatric hospitals represent a significant and under recognized occupational hazard [15]. Not only the exposure rate to violence is higher among psychiatric staff, but also the number of violent attack was higher. More than 80% of psychiatric staff was exposed to violence during the past year (with a mean of 5.9 violent event), compared to only 23% in internal medicine staff (with a mean of 2.0 violent events). Similar higher rates up to 73% were reported in different studies among psychiatrists in USA[16]. However a lower rate (28%) was reported in Australia[17].

Verbal violence by far is the commonest type to be reported followed by threat and lastly physical violence in both psychiatric and internal medicine staff, (80.6%, 58.1%, 29% vs. 23.2%, 8.3%, 7.3% respectively) however, both the incidence and number of these different types of violence were significantly higher among psychiatric staff. A previous study reported that 73% of psychiatric residents were being threatened and 36% had been physically assaulted[18].

Among psychiatric staff the incidence of violence increases among younger age groups and with shorter duration of work. Health care workers with least experience are at greater risk of assault[17]. May and Grubb[19] reported that the experience to deal with potentially violent situations increased with long duration of work and increased age group. Privitera et al,[5] reported that work experience is a protective factor, but not a guarantee against violent events.

In both psychiatric and internal medicine staff nurses and doctors were exposed to more violence than social workers/psychologists. Previous studies reported the same finding among nursing staff[20,21]. Nursing staff members are more exposed to an incident of aggression or violence, which may be due to their availability[21]; also they are the health care personnel come in the first and frequent contact with patients and their relatives.

In the opinion of both samples, the most frequent contributing factors to violence are dissatisfaction with treatment, overcrowding, insufficient staff and inadequate security. Multiple studies have demonstrated that individuals with severe psychiatric disorders who are being inadequately treated or not treated at all are more likely to be violent than the general population[22-24]. In an Australian study, the commonest contributing factors were mental health condition of patients and security problems[5]. More than (79.2%) of staff reported that violent events occur during visiting times similar to that reported by Kathleen et al, [25].

Most of consequences of violence are psychological in the form of anger, irritability and anxiety. The same consequences were reported in different proportions in a previous study[8]. Minority of victims reported

pain/scratches/contusion. This contradicts a previous study where 58% of violent events were serious[21]. In an Australian study, staff injury was reported in 5% of cases[17].

The vast majorities of assailant are males, of less than 40 years age, patients' relatives, patients themselves, and have lower educational levels. Other studies [26,27] reported that, the assailant usually males and middle age group (20-40 years), Also Chen et al [28] reported that troublemakers were patients relatives and patient themselves. However, Jenkins et al[29] stated that patients were chief perpetrators of violence.

In conclusion work place violence against psychiatry staff is more frequent than those working in internal medicine department. Violence in psychiatric settings can be managed by effective program based on comprehensive, inter-disciplinary hazard assessment and incident investigation. Improvement of work circumstances e.g. providing more experienced staff, adequate treatment of psychiatric patients, avoiding overcrowding, will contribute to decreased risk of violence against psychiatric staff. There is a need for staff training to enhance team-building, improve communications, and encouraging report

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Correspondence

Mr Abdel-Hady
Professor of Public Health, Faculty of Medicine
Mansoura University
El-Gommhoria street
35516 Mansoura
Egypt
+50 160 714 481
ahgilany@gmail.com

Developing sustainable strategies for assisting assaulted mental health nurses

Paper

Charles Harmon
University of Newcastle, Callaghan, Australia

Introduction

Patient violence has become a major issue in mental health facilities in Australia.[1-3] In the state of New South Wales health department policy requires all staff who have contact with patients to engage in mandatory training in the management of aggression. Staff who experience violence are strongly encouraged to report the incident; and it is the responsibility of line managers to enquire about the staff member's recovery and to inform them of the availability of the employee assistance program (EAP) which is an independent counselling service funded by NSW Health.[4]

International researchers have reported on mental health nurses' experiences of being assaulted by patients[5-9] but there are gaps in the literature about how mental health nurses respond following assault by their patients. In particular the present researcher was interested in the source of the anger and distress reported by assaulted nurses as well as the relevance of the victims' work environment in shaping their responses post-assault. The extent to which the employment of post-assault coping strategies such as avoidance and denial diminishes the capacity of nurses to engage therapeutically with patients[6, 7] was another issue of concern.

Methodology

This prospective study examined the responses of mental health nurses to the experience of patient-initiated assault using mixed methods but primarily employing the grounded theory method described by Glaser. [10-12] The study was designed to address two research questions:
1. What is the process of response of mental health nurses to assaults by patients?
2. What is the effect of a recent (patient-initiated) assault upon the ability of the mental health nurse to engage therapeutically with her/his patients?

For this study patient assault was defined as:
1. Any interaction between a nurse and a patient that results in a staff member feeling personally threatened and distressed (e.g. where the nurse is verbally threatened) OR
2. Any interaction between a nurse and a patient where there is unwanted physical contact and the nurse sustains an injury (such as where the nurse is injured following a physical attack or during a restraint procedure) or where there is an exchange of body fluid (e.g. where the nurse is spat upon).[8]

The study was conducted in two phases within the inpatient units of a public mental health service located in regional New South Wales, Australia. Phase one of the study involved close observations of nurses in acute inpatient settings and will be published separately. During phase two of the project (July 2003 to August 2004), sixteen volunteer nurses were interviewed within three weeks of being assaulted by a patient using: the Assault Response Questionnaire (ARQ)[8], a 61-item questionnaire which measures a range of responses (such as anger and anxiety) on a five-point scale from 'none' to 'slight' through to 'severe'; and a demographic data form. Two follow-up semi-structured interviews were also conducted with this sample of nurses at three months and six months post-assault. The second and third interviews were broadly scripted to explore the following dimensions: working conditions; the nurse's ongoing responses to assault; changes in response over time; moderating factors which might affect coping; individual coping strategies; and relationships with patients and colleagues. Questions were posed broadly: "Tell me, how you have been coping since your assault?" and "Have you experienced any difficulties in the way in which you relate to patients since the assault?" Interviews progressed until it became clear that there was data saturation.

Data were analysed as they were collected using the grounded theory approach outlined by Glaser[10-12] in which the raw data were 'broken up' via a process known as open coding and then placed into interim

categories on the basis of shared characteristics. The data were then analysed with the aim of constructing categories with greater levels of abstraction and, hence, greater capacity to explain variation within the data. These activities were facilitated by the basic processes of memo writing, questioning the data and making theoretical comparisons; with the dual aims of facilitating categorisation of the data and verification of the procedures.

Results

Of the sixteen nurses interviewed for phase two of the project, eleven were males. Ages ranged from 26 to 55 years of age. Nursing experience ranged from one year to 25 years. Ten of the nurses reported 50 or more previous assaults during their careers. The most common form of assault reported for this study was a single punch. Five of the nurses reported experiencing a severe level of threat during their assault and six reported experiencing a moderate level of threat and five reported experiencing a mild or negligible level of threat.

Overall, responses on the ARQ tended to be reported mostly at 'mild' and 'moderate' levels with most participants recording at least one response in the 'fairly intense' or 'severe' categories. Responses typically included feelings of anger, anxiety and disbelief that the assault had occurred. The main purpose of using the initial questionnaires was to provide baseline data and to establish a 'language' that might facilitate the description of feelings during subsequent interviews.

During the second interview five of the inpatient mental health nurses reported experiencing only mild discomfort for several hours after they had been assaulted by a patient, and two participants reported mild responses for up to four days. In contrast nine participants reported strong reactions to their experience of assault and commenced a process of recovery, lasting from several weeks to months, marked by two distinct phases which were subsequently labelled *churning anxiety* and *reintegration* (see figure 1).

Core problem: Overcoming futility focused about the assault
Basic social process: Moving from passive to active coping strategies
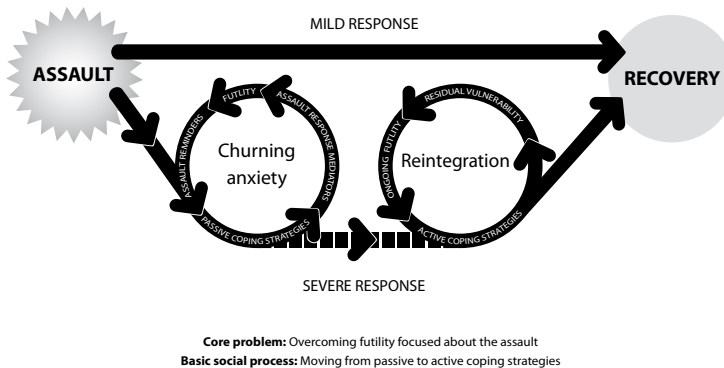
Figure 1: Depiction of the recovery trajectory for Phase Two participants as they moved from passive to active coping strategies.

Features of the churning anxiety phase were:
- Assault reminders: including ongoing distress related to fear of the assaultive patient and intrusive thoughts about the assault.
- Passive coping behaviours: including passive management strategies for personal emotions (such as minimising the importance of the assault or not thinking about it) and passive patient management strategies (such as keeping a distance from patients and not engaging with them).
- Assault response mediators. Participants who reported the perception that they had received 'adequate' support from colleagues during the post-assault period said that this experience helped to alleviate their distress. Those who reported the perception that colleagues (especially nurse managers) were not supportive, reported an exacerbation of their distress.
- Futility: related to the participants' continued expectation of being assaulted as well as the perception that their nurse managers had not acknowledged their distress.

It was hypothesised that PTSD theory is a useful vehicle for analysing the coping behaviours reported by participants such as the minimisation and suppression of psychological reactions. An example of the

suppression of post-assault responses in the present study was identified in the four participants who reported that they were 'over' the effects of their assault at interview two before realising that they had underestimated the duration of their reactions to their assault by several weeks at interview three.

The reintegration phase marked a departure from the passive coping strategies which were a feature of the churning anxiety phase of recovery. Participants engaged in the reintegration phase of recovery reported adopting:

- Active strategies in the management of their professional lives including: active patient management strategies (such as being more assertive with their patients); and actively managing safety concerns (such as participating in work safety programs and considering a new, and safer, job).
- Residual vulnerability: particularly in relation to the presence of aggressive patients.
- Ongoing futility: related to the perception that nurse managers were ignoring the requirement for improvements to workplace safety.

Whilst support from peers was valued there was an overall perception that a lack of support from nurse managers made recovery more difficult. Participant 'John', for example, reported that his line manager had ignored him after his assault which made him feel *"unsupported"* declaring *"... that's one of my major gripes* [regarding my assault] ... *I don't feel supported here by administration"*. Similarly 'George' reported his continued frustration that *"... it seems to me that* [the nurse manager] *should have had someone approach me or say, you know, do you want to talk about this ... but it didn't happen"*. 'Louise' described the lack of support that she received as "stressful". Indeed nine of the participants reported either dissatisfaction with the level of support received from their nurse manager or that they had received no contact at all. Moreover only seven of the sixteen participants in this study were informed, by their nurse manager staff, of their right to access EAP to assist with the alleviation of their distress.

Discussion

Some nurse managers may have experienced difficulty recognising the distress of the participants in the post assault period and consequently did not offer support to the satisfaction of the participants. This lack of recognition may be influenced by the assaulted nurses' minimisation and/or suppression of the psychological impacts due to their assault. However, in most cases, the relevant nurse manager either did not enquire about the participant's level of distress or only enquired about their distress during the 24 hours following the assault. This behaviour may be due a lack of awareness about the possible psychological effects of patient assault or to the perception that patient initiated violence is just part of the job.[13]

According to Lazarus and Folkman[14] the ability of people to access and use social support is a key factor in alleviating stress. Further, the primacy of social support as a mitigating factor against the severity of post trauma responses is emphasised in a meta analysis by Brewin and Holmes.[15] However there appears to be a special expectation attributed to nurse managers by the participants in this study. One explanation may be that the nurses working for the particular health service, whether they have been assaulted or not, have come to expect low levels of support in their workplace.

If this is so nurse managers require education about the benefits of being more supportive toward assaulted staff. One venue for the dissemination of information on the potential effects of patient violence upon nursing staff is the mandatory aggression management program. These programs have proliferated in Australia and abroad since the mid-1990s and into the current decade. However Farrell and Cubit,[16] in their audit of 28 management of aggression programs in eight countries including Australia, Canada, Ireland, Japan, New Zealand, Switzerland, the UK, and the USA, reported that the content of these programs varied widely with several omissions. In the discussion of their findings Farrell and Cubit[16, (p. 51)] stated:

"Most programs appear not to address the psychological and organizational (sic) effects associated with aggression. This is surprising since the literature suggests that the effects of aggression are wide and varied, including increased absenteeism and sick leave, property damage, decreased productivity, security costs, litigation, worker's compensation, reduced job satisfaction together with recruitment and retention issues".

There is a clear case for better preparation of mental health staff in respect of the potential effects of patient assaults (including information on strategies for the recognition of post-assault distress in colleagues and the subsequent potential for professional disengagement by victims of assault). Specific training for nurse managers is also indicated regarding: the importance of their role in the recovery of assaulted staff and also the requirement for them to engage in: pastoral care in enquiring on a more regular basis about the welfare of assaulted nurses; and the initial counselling of assaulted nurses followed by subsequent referral to more specialised support services such as EAP.

The potential benefits of nurse managers providing support for assaulted nurses are outlined by Kanaisky and Norris[17] who described the effects of increased levels of perceived support which, they found in their research with victims of violent crime, promoted well-being regardless of the distress experienced by victims. Kanaisky and Norris[17, p. 220] described the elements of *perceived support* as: *perceived appraisal support* (the perceived availability of both emotional support and guidance); *perceived tangible support* (such as providing time off from duties); and *perceived self- esteem support* (the availability of reassurance of self-worth). There also appears to be benefits in respect of increased competency of assaulted staff and improved workplace morale. Deans,[18] in his study, revealed that among assaulted nurses who reported experiencing relatively high levels of occupational violence, there was a significant relationship between perceived higher levels of organisational support and higher levels of perceived professional competence.

Historically critical incident stress debriefing (CISD) was provided to assaulted nurses on a routine basis. This practice was discontinued in NSW Health facilities due to controversies about whether the process of CISD may effectively 'pathologise' normal responses to the experience of traumatic such as denial and forgetting[19] and doubts as to the effectiveness of CISD in reducing distress and longer-term psychological sequelae.[20] Although a return to the practice of CISD is not being advocated in this paper it might be argued that the end of this practice has created a vacuum in the provision of effective organisational support. Practical measures which serve to fill this vacuum might be explored in future research including: the appointment of specific occupational health staff who might assist in the ongoing monitoring and support of assaulted nurse; the creation of support groups for assaulted nurses and the option of clinical supervision for all assaulted nurses who experience distress. There is limited research into the effectiveness of support groups[21] and clinical supervision[22] as means of reducing the stress experienced by individuals in relation to patient assaults. However there may be benefits associated with these strategies as their provision may increase the degree of *perceived support*.

Conclusion

A number of recommendations may be made on the basis of the study findings. New policy directions may include: the incorporation of information on the psychological effects of patient violence (regardless of the presence of physical injury) in aggression management programs; and specific contributions of nursing administration staff in the ongoing support of victims of violence. Strategies which improve the degree of perceived support by nursing staff should also be considered. One possible area for future research might be to study nurse managers' responses to staff who have been assaulted by patients, to investigate what managers think they ought to be doing and what they are actually doing. Future research might also focus on evaluating the impact of multiple support strategies, including clinical supervision and the introduction of support groups. These are achievable strategies which may facilitate a sustainable future in the provision of support for assaulted nurses.

Acknowledgements

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Correspondence

Mr Charles Harmon
University of Newcastle
University Drive
2308
Callaghan
Australia
+61 249 216 324
charles.harmon@newcastle.edu.au

Violence at work: Response stress and coping resources

Poster

Elizabete Borges, Teresa Rodrigues Ferreira
Oporto Nursing School, Porto, Portugal

Abstract

Background

One of the many examples that interfere in worker's quality of life is Occupational Stress. For his specific nature, nursing is a profession which evidences high degrees of stress, in part by their specific tasks and the people under their care.

Aim

This study aimed to describe the stress response, the coping resources and the association between violence, stress response and stress coping resources in Portuguese nurses.

Materials and methods

It is an exploratory and descriptive type of study, integrated within the paradigm of quantitative research. The sample is made up of nurses / students of the Post-Graduation Course of the Porto Nursing School (N=151), who accepted to collaborate in the study. The instrument for collecting data was the Socio-demographic and professional form and the "Answers and Personal Resources Inventory" Portuguese version of the Brief Personal Survey (McIntyre, McIntyre & Silverio, 1995). The Cronbach Alfa coefficient, for the total scale was 0.74.

Results

The results we would highlight that in a sample of 151 nurses 84.8% were female. The minimum age was 24 years and the maximum 54 years, and the average was 33.1 years (SD= 5.659). Regarding the professional category 36 (65.6 %) graduated. The nurses had 10.3 years working experience and 73,3% were the permanent staff of the institution. From the analyses of the medium values obtained in the different scales of the IRPP, we observe that Social Support is scale which present the highest average (M= 84.1, DP= 23.1) of the scales the coping resources. In the scales of response to the Stress, the scale Pressure-Overload was the one with the highest average (M=49.7, DP= 25.7). On the other hand Depression was the answer to stress least used by the nurses, with the lowest average M=28.0 (DP=26.1). The most prevalent responses to stress are Pressure-Overload, distress and health, anxiety, dysphoric emotionality, and anger and frustration. These results to stress response evidence of a dominance of the psychological stress expressions. The data shows association positive and low between violence, stress response and stress coping resources r (129)=0.34, p<0.01.

Conclusion

Nurses lack of assistance in programs of emotional management in their workplace, within the institution in order to reduce the effects of occupational stress and need programs on violence in the workplace.

Correspondence

Mrs Elizabete Borges
Oporto Nursing School
Rua Dr. António Bernardino de Almeida
4200-072
Porto
Portugal
+351 225 073 500
elizabete@esenf.pt

Workplace violence (WPV): Effect on staff, institution, and quality of patient care

Paper

Michael Privitera, Judy Arnetz
University of Rochester, Rochester, New York, USA

Abstract

WPV toward staff in general and mental healthcare settings is an underreported but frequent problem across many settings and countries. The focus of this paper is mostly on Type II violence (from patients), although Type III violence (worker-on-worker) is also relevant to disruptive behavior that affects quality of patient care. Organizational contributions to Type II and Type III violence has not been listed in Cal/OSHA and FBI Typology, but we concur with Bowie that it needs to be, whether called a new Type IV, or to be called Type V will need further discussion.

A study of four hundred healthcare workers in Australia of 12 months period reports the following forms of WPV: verbal abuse 67%, threats 33%, assault 12%, bullying 10.5%, other 11%. Total victimized 67%.

A study of 380 staff respondents in a department of psychiatry in the US, showed prevalence of career threats / assaults: registered nurses 81%/57%, advanced practice nurses 69%/54%, physicians 71%/40%, and bachelor level social workers 62%/23%.

An international survey of nurses from 18 countries showed that 80 % of nurse leaders had experience some form of violence. Barriers or misperceptions have included ambivalent corporate advocacy for staff victims in the current environment of hyper-scrutiny by regulatory agencies about patient harm (not realizing the effect of WPV on staff ultimately affecting quality of patient care), concerns over the public image of the institution (competitive with other local institutions), litigiousness of patients, as well as very reasonable efforts to decriminalize the mentally ill. Forces that lead to underreporting then perpetuate inaction, as "no data means no problem". Hence, the case for true impact of WPV (financial, operational, and patient care), has yet to be fully determined.

Budgetary discipline and agency silo effects have impaired needed interdepartmental and community agency coalitions required for the needed synergy of solutions. Cognitive dissonance involved in the patient/care-giver to perpetrator/staff-victim role transition raises the risk of increased staff injury. Loss of self confidence, depression, and stress-related disorders including PTSD occur.

Negative outcomes to the institution include low worker morale, increased staff turnover, direct and indirect effects on work ability. The average cost per WPV injury was 5716 (1989 USD), 32 days lost, 11 days restricted duty. Arnetz and Arnetz demonstrated the statistical association between staff experiences with violence and both lower staff-rated and patient-rated quality of care. Lack of clear managerial and corporate support to the staff-victim are precipitating and perpetuating factors to decreased ability to work at pre-violence capability. Reininghaus et al demonstrated manager support post event had a statistically significant affect on lowering psychological distress. Lessening secondary stressors occurring from physical assault can reduce psychological distress as well. Organization contributions to violence (patient-on-staff and staff-on-staff) in healthcare are outlined below:

- Staff cuts, organizational decisions, less staff, over work, fatigue, decreased services, longer waiting times patient, interactional stress, immunity and tolerance to patient demands, violent response.
- Managerial bullying, closely associated with major organizational change, high workload, negative work environment and unsatisfactory relationships at work.
- Managerial lack of dignity and parallel process, respect toward employees by means of economic rationalism trickle down effect toward patients at the institution.

Educational goals
- To cover number of possible suggestions and strategies in the presentation, and encourage discussion of ideas on implementation reviewing the need for managerial and corporate support of staff-victims.

- To make the point that the impact of WPV on patient care appears to be a missing link that can align purposes and interests of regulatory agencies (hence healthcare administration) with staff for sustainability of initiatives, better safety of staff and better patient care.

Correspondence

Mr Michael Privitera
University of Rochester
300 Crittenden Blvd
14642
Rochester, New York
USA
+1 585 273 5701
michael_privitera@urmc.rochester.edu

Perpetrators of violence against paramedic's in the workplace and the paramedic's response

Paper

Malcolm Boyle, Stella Koritsas, Jan Coles
Monash University, Frankston, Australia

Introduction

Violent and aggressive behaviour is reported to be widely experienced across healthcare and welfare disciplines in Australia (1-3). Studies have found it to be so all-encompassing in these occupations that it is often seen as 'part of the job' and therefore 'acceptable' rather than a harmful activity needing assessment and management in the work environment (4, 5). Studies of emergency medical service (EMS) personnel in the USA have reported that 61% were assaulted during the course of their work and that 25% had sustained an injury from workplace violence (6, 7). A Swedish study found approximately 80% of paramedics had been threatened or subject to violence when performing their work with most of these violent acts from a patient, relative or friend (8). Suserund et al also found that 98% of paramedics felt that threats or actual violence from the patient altered the relationship with the patient and that 80% of paramedics felt the care provided to patients was altered by threats or violence from relatives. There is a lack of evidence covering the perpetrators of violence against paramedics and the paramedic's response to the violence, especially in Australia. The objective of this study was to identify who was responsible for the different forms of workplace violence against paramedics and the response of paramedics to the violence.

Methods

Study Design
This study utilised a cross sectional methodology with a paper-based questionnaire using a convenience sample to elicit paramedics responses to workplace violence.

Setting
This study was undertaken in two states of Australia. Victoria is a south eastern state of Australia covering approximately 227,590 square kilometres with an approximate population of some 4.9 million people (9). South Australia is a southern state of Australia covering approximately 984,377 square kilometres with an approximate population of some 1.5 million people (9). The Rural Ambulance Victoria (RAV) has some 113 ambulance stations with approximately 310 ambulances and a staff of approximately 1100, including volunteer staff located in the more isolated and low workload areas of the state(10). SAAS has some 104 ambulance stations with approximately 200 ambulances and a staff of approximately 1,900 including volunteer staff located in the more isolated and low workload areas of the state. In the metropolitan area, SAAS has 19 ambulance stations and an on road staff of approximately 430 (11).

Population
Participants eligible for inclusion in the study were paramedics from the rural ambulance service in Victoria, RAV and metropolitan staff from SAAS.

Definitions
We defined workplace violence as violence that was associated with work. As such it included violence that occurred in the ambulance station or offices where management was housed, the ambulance itself, a health care facility, and the incident location. Workplace violence perpetrators included, but were not limited to, other paramedic staff (including all management levels), the patient, the patient's relative or friend, incident bystanders, other emergency service staff (fire and police), and health care facility staff. Other definitions of workplace violence have been described elsewhere (12).

Instrument
A questionnaire was developed to explore paramedics' experience of workplace violence which has been described elsewhere (12).

Procedure

The survey was distributed by the respective ambulance service (RAV and SAAS) to their staff. RAV distributed 500 questionnaires to their paramedics with SAAS distributing 430 questionnaires to their metropolitan paramedics. Paramedics completed the questionnaire and returned it using a reply paid envelope to the research assistant. There was no follow up letter sent to the participants to encourage them to complete the survey.

Data Analysis

Descriptive data analysis was undertaken using SPSS (Statistical Package for the Social Sciences Version 17.0, SPSS Inc., Chicago, Illinios, U.S.A.). Descriptive statistics were used to report the demographics and exposure to the specific violent episodes. The results are considered statistically significance if the p value is < 0.05, all confidence intervals (CI) are 95%.

Ethics

Ethics approval for this study was granted by the Monash University Standing Committee for Ethics in Research on Humans.

Results

For RAV there were 152 questionnaires returned, four of which were returned to the researchers due to a change of address and hence excluded. The response for RAV paramedics was therefore 29.6%. For SAAS 108 questionnaires were returned with one excluded due to a change of address. The response rate was therefore 25.1%. A total of 930 questionnaires were distributed with an overall response rate of 28%.

There were 74.5% males, 24.3% female, and 1.2% not defined. The median age of respondents was 41 years, range 21 years to 62 years. The median number of years experience the paramedics had was 14 years, range 6 months to 39 years. Of the paramedics surveyed 87.5% had experienced at least one form of violence associated with the workplace in the last 12 months.

Most paramedics indicated that there were multiple perpetrators during the incident that worried them most. In most verbal abuse cases, the perpetrator(s) was the patient or their families, relatives, companions or friends. In most property damage or theft cases, the perpetrator(s) were other professionals, work colleagues, or other professionals (see Table 1).

Table 1: Main perpetrators of abuse, according to type of abuse experienced.

	Patient/client	Patient's/client's families, relatives, companion/friend	Other professional or colleague	Bystander	Other
Verbal abuse	47.2%	31.5%	8.6%	12%	0.7%
Property damage or theft	20%	13.3%	26.7%	8.8%	31.1%
Intimidation	27.8%	27.2%	37.6%	6.4%	1.2%
Physical abuse	83.5%	10.3%	3.1%	3.1%	-
Sexual harassment	45.5%	16.4%	32.7%	0.5%	-
Sexual assault	38.5%	15.4%	46.2%	-	-

Table 2 displays the gender of the main perpetrator(s) of abuse and shows that for all types of abuse, the gender of the perpetrator was most often male.

Table 2: Gender of perpetrator, according to type of abuse.

	Male	Female
Verbal abuse	71.7%	28.3%
Property damage or theft	81.8%	18.2%
Intimidation	76.6%	23.4%
Physical abuse	70.2%	29.8%
Sexual harassment	69%	31%
Sexual assault	81.1%	18.2%

The level of fear experienced during the incident varied according to the type of violence experienced (Table 3). Those experiencing verbal abuse or intimidation were generally mildly or quite apprehensive

whereas the majority of those who had been subjected to property damage or theft experienced no fear. People who had experienced physical abuse were generally quite apprehensive or frightened by the incident. Those experiencing sexual harassment were mainly mildly apprehensive, however those experiencing sexual assault were very frightened.

Table 3: Level of fear experienced during the violent incident

Verbal abuse	11.4%	39.5%	36.28%	9.0%	3.8%
Property damage or theft	52.8%	19.4%	13.9%	11.1%	2.8%
Intimidation	9.4%	39.6%	40.3%	10.1%	0.7%
Physical abuse	9.4%	26.0%	39.6%	20.8%	4.2%
Sexual harassment	30.0%	52.5%	12.5%	5.0%	-
Sexual assault	10%	40%	20%	30%	-

Still relating to the specific incident of violence that worried paramedics the most, paramedics were asked to identify factors that they believed to have precipitated the violent incident. Drug and alcohol consumption were two factors commonly identified by paramedics as having precipitated the violent incident (refer to Table 4). For physical abuse, another common precipitator was service dissatisfaction. Psychological or mental health problems were also identified as a precipitator, particularly for intimidation, property damage or theft, and verbal abuse.

Table 4: Factors, according to type of violence, that were believed to have precipitated the violent incident

	Verbal abuse	Property damage or theft	Intimidation	Physical abuse	Sexual harassment	Sexual assault
Drugs	15.7%	4.3%	13.6%	10.3%	3.4%	12.5%
Alcohol	44.6%	26%	29.9%	39.7%	51.7%	37.5%
Service dissatisfaction	6.2%	4.3%	6.5%	33.3%		-
Psychological problems/ mental health	18%	26%	16.2%	0.8%	3.4%	-
Social	1.3%	-	-	8.7%	-	-
Racially motivated or cultural differences	3.3%	-	0.6%	-	-	12.5%
Work problems	0.3%	-	0.6%	-	3.4%	-
Disability	0.7%	-	1.3%	2.4%	-	-
Stress, anger or frustration	1.3%	-	3.2%	-	-	-
Robbery/burglary	-	4.3%	0.6%	-	-	-
Jealousy	-	4.3%	0.6%	-	-	-
Sexual/gender	-	-	0.6%	-	-	-
Need to control	-	-	0.6%	-	-	-
Dementia	-	-	-	3.2%	-	-
Family problems	-	-	-	0.8%	-	-
Other	8.5%	30%	24%	0.8%	24.1%	25%

Paramedics' immediate response(s) to the abuse they identified as particularly worrisome, are shown in Table 5. Many paramedics responded in more than one way. A common factor believed to have precipitated many of the violence incidents was alcohol use. Drugs, service dissatisfaction and psychological or mental health problems were also factors cited commonly as having precipitated violence.

Immediate responses to the violent incident that worried them particularly are displayed in Table 5. Responses varied according to the type of violence that was experienced by the person. Common responses to verbal abuse included staying calm, diffusing the situation, or trying to reason with the person, followed by calling or talking to the police. Some paramedics also responded by backing off altogether or leaving the room, or doing nothing at all. The most common response for theft was calling or talking to the police, followed by doing nothing or talking to a senior professional about the incident. There were a wide range of responses to intimidation including calling or talking to the police and staying calm, diffusing the

situation, or trying to reason with the person. For physical abuse, the most common response by far was to call or talk to the police. When paramedics were exposed to sexual harassment, the most common response was to do nothing. For sexual assault, the most common response was to back off or leave the room, followed by doing nothing. It is worth noting, that talking to a senior professional or debriefing with another staff member, did not appear to be common responses to violence.

Table 5: Immediate response/s to abuse

	Verbal abuse	Property damage or heft	Intimi-dation	Physical abuse	Sexual harassment	Sexual assault
Police	27.4%	37.5%	18.3%	40%	4.3%	8.3%
Senior professional	2.4%	15%	11.8%	-	4.3%	-
Asked person to leave	0.8%	-	0.7%	-	-	-
Did nothing	11.1%	20%	14.4%	3.2%	34.8%	16.7%
Backed off	17.1%	7.5%	15.7%	17.6%	10.9%	8.3%
Stayed clam	25.8%	2.5%	17.7%	9.6%	15.2%	33.3%
Called security	2.4%	-	4.6%	3.2%	-	-
Was angry	1.6%	-	2%	0.8%	-	8.3%
Gave them what they wanted	0.4%	-	-	-	-	-
Gave up care to other	1.2%	-	0.7%	0.8%	-	8.3%
Asked for help	1.6%	-	-	4%	2.2%	-
Hit them	0.4%	-	-	1.6%	-	-
Debrief with staff	0.4%	5%	1.3%	0.8%	4.3%	-
Restrained them	-	-	-	11.2%	-	-
Laughed it off	-	-	-	-	8.7%	-
Other	7.5%	12.5%	13.1%	7.2%	15.2%	16.7%

In terms of responses to violence, paramedics were also asked to indicate the degree to which they performed certain actions after a violent incident occurred. These responses are displayed in Table 6.

Table 6: How often paramedics responded in particular ways after the violence occurred

	Never	Once	Sometimes	Often	Always
Did nothing	21.6%	5.1%	18.0%	8.2%	2.7%
Discussed with family and/or friends	4.3%	9.4%	18.4%	16.1%	11.8%
Discussed with colleagues	1.2%	5.9%	14.1%	22.4%	18.4%
Discussed with supervisor/mentor	13.7%	11.8%	20.0%	7.5%	7.1%
Received professional debriefing/counselling	45.1%	8.2%	3.5%	2.0%	0.8%
Completed and incident report	20.4%	14.5%	12.5%	7.5%	5.5%
Took days off work	49.8%	4.7%	3.1%	0.8%	1.6%
Took on a different role	54.5%	2.0%	2.0%	0.4%	-
Sought medical attention	49.0%	6.3%	2.7%	0.4%	1.2%

More than half of the paramedics surveyed never took on a different role after a violent incident. Almost half of the paramedics never took days off work, sought medical attention or received professional debriefing or counselling. Some paramedics however said that they always, often or sometimes discussed the incident with colleagues or with family and/or friends. A very small number of paramedics (n=6) listed other responses such as walking exercising, looked for other work.

The questionnaire also included the Impact of Event Scale (IES). This scale was devised to measure current subjective distress related to a specific event. Since its development it has come to be considered as one of the earliest self-report measures of post-traumatic disturbance. The cut off point for the total stress score is 26, above which a moderate or severe impact is indicated. The IES can be interpreted according to the following dimensions: 0 to 8 points = Sub clinical range; 9 to 25 points = Mild range; 26 to 43 points Moderate range; 44 points or more = Severe range. Means and standard deviations for the total scale and subscales are presented in Table 7.

Table 7: Mean scores and standard deviations (SD) on the Avoidance subscale, Intrusion subscale and total scale of the Impact of Event Scale according to occupation

	Mean(SD)	CI	P value
Avoidance	7.52(9.19)	6.39 to 8.65	< 0.0001
Intrusion	7.28(8.24)	6.26 to 8.30	< 0.0001
Total	14.80(16.63)	12.75 to 16.85	< 0.0001

The norms report an average score of 20.8 for the avoidance subscale and 21.02 for the intrusion subscale, Table 7. The scores obtained by paramedics in this sample are well below this, although the mean total score indicates that there were some paramedics who scored in the mild clinical range. The large standard deviation of the total score indicates that there are some paramedics who scored in the moderate clinical range.

Conclusion

Paramedics were predominately apprehensive as a result of a violent act and were unlikely to seek any form of professional assistance following a violent incident, but are more likely to discuss the incident and associated issues with colleagues. The incidence of sexual harassment or assault by work colleagues or other closely related professionals is alarmingly high and the lack of response by paramedics is of concern.

Acknowledgements

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Correspondence

Mr Malcolm Boyle
Monash University
P.O. Box 527
3199
Frankston
Australia
+61 3 9904 4176
mal.boyle@med.monash.edu.au

Fearing the other: Exploring the impact of violence on the nurse-patient relationship in forensic psychiatry

Paper

Jean Daniel Jacob
University of Ottawa, Ottawa, Canada

Abstract

Study: The goal of this research project was to describe and comprehend how fear influences nursing interactions with patients in a forensic psychiatric setting. This research was conducted in Canada and was funded by the Social Sciences and Humanities Research Council of Canada.

Method: Qualitative design. Data collection: Mute evidence (institutional documents), direct observation of the setting, and 18 semi-structured interviews. Data analysis: In keeping with an inductive methodological framework, the analysis of the data followed grounded theory principles and produced four mutually exclusive categories: 1.) Context, 2.) Nursing Care, 3.) Fear, and 4.) Othering.

Results: In brief, the results from this research indicate that nurses are socialized to incorporate representations of the forensic psychiatric patient population as being potentially dangerous, and, as a result, distance themselves from idealistic conceptions of care. Moreover, the research results emphasize the implication of fear in nurse-patient interactions and particularly how fear reinforces nurses' need to create a safe environment in order to practice. A constant negotiation between space, bodies and security takes place where nurses are forced to scrutinize their actions (self-discipline) in order to avoid becoming victims of violence. As a result, security is a factor that needs to be present in order for care to be provided. If the environment is considered to be unsafe, then interventions to secure the space are inevitable. In light of the risk of violence, participants described a process (Othering) that either facilitated or hindered therapeutic interventions. Most importantly, exposure to the patient's criminal history, as well as the inability to rationalize the patient's behaviours within a sickness model, proved to be central elements in the nurse's ability to engage in a therapeutic interaction with patients.

Introduction/Background

Nursing practice in forensic psychiatric environments proves to be particularly complex, as "[…] nursing personnel must assume functions regarding social control and psychiatric care in a hybrid work environment in which hospitals and prisons merge" (Holmes, 2005, p. 3). In effect, as many authors have described, the difficulty associated with nursing care in forensic psychiatric settings revolves around the articulation of therapy and security imperatives (Burrow, 1998; Holmes, 2001; Holmes & Federman, 2003; Mason, 2002; Peternlej-Taylor, 2004). Forensic psychiatric nurses are constantly torn between the ideal of care - to establish a reciprocal and trusting relationship (Peplau, 1992) - and the realities of a security discourse.

In addition to this complex professional role, nurses working in forensic psychiatric settings must face yet another duality: the role of carer in which maintaining one's own right to safety is in opposition to offering the best quality of care (Needham, 2006). If a higher risk of violence in forensic psychiatry is not evident, it is nonetheless perceived as so (Mason, Coyle & Lovell, 2008). According to Mason, Lovell and Coyle (2008), the prerogatives of nursing work in a potentially violent environment induces fear, even if stressful situations only periodically spill into acute states of actual violence. This perception of threat or fear is what differentiates the forensic psychiatric environment from traditional hospital settings (medical or surgical units). In this area of practice, where patients are believed to be dangerous, the perceived risk of violence and the need for personal safety reconfigure nurse-patient interactions (Whittington & Balsamo, 1998). Such a reconfiguration may very well lead to an ethical dilemma as nurses are caught between their intentions to fulfil professional standards while concurrently attempting to safeguard and maintain their own rights to personal safety (Needham, 2006). Despite a growing body of literature addressing the issue of violence in nursing (Arnetz & Arnetz, 2001; Duxbury & Whittington, 2005; Foster, Bowers & Nijman, 2007; Kindy, Petersen & Pakhurst, 2005; Morrison, 1990; Needham, 2006), nurses' fear of patients is not a topic that has been openly discussed in forensic psychiatry, and as a result remains under-theorized (Mason, 2002; Morrison, 1990).

This research project (Jacob, 2010) is thus situated at the crossroads of two distinct disciplinary fields: nursing and criminology. It seeks not only to situate nursing practice in an extreme environment, but also to explore a professional practice in a context where the probability of nurses becoming victims of interpersonal violence is considered to be high, and where fear becomes a perceptible variable that shapes nurse-patient interactions (Whittington & Balsamo, 1998). As such, the goal of this research project was to describe and comprehend how fear influences nursing interactions with patients in a forensic psychiatric setting.

Method

The use of a grounded theory, which incorporates explorative and descriptive attributes, was thought to be an appropriate methodological choice for this research project. During 4 months, 18 semi-structured interviews with nurses were conducted and accounted for the primary source of data. Direct observations and the analysis of mute evidence (institutional documents) were also part of data collection strategies. In keeping with an inductive methodological framework, the use of a grounded theory produced four mutually exclusive categories: *context, nursing care, fear and, othering*.

Summary of Results

Context and Nursing Care:
As the research results suggest, the contextual elements of the forensic psychiatric institution reconfigure nursing ideals of care (Jacob & Holmes, Forthcoming publication). Safety and security rationales become central elements in day-to-day interactions with patients. In effect, nurses described that being security-minded is a central element of forensic psychiatric nursing. Security and nursing care not only coexist, but one needs to be present for the other to take place. If the perception of security/safety cannot be achieved, then nursing care becomes difficult, if not impossible, to exercise.

In parallel, the results from this research indicate that nurses are socialized to incorporate representations of the forensic psychiatric patient population as being potentially dangerous, and, consequently, distance themselves from idealistic conceptions of care. Once nurses enter forensic psychiatric environments, they are immersed in a culture of risk (Holmes, 2001; Holmes, 2005; Homes & Federman, 2003; Mason, 2002; Perron, 2008). Over time, nurses developed a new clinical scheme of reference that is rooted in suspicion and a subsequent heightened sense of awareness. It is this new clinical scheme of reference that accounts for a distanciation from original conceptions of nursing care to a scheme of reference that is coloured by safety and security rationales. Nurses are constantly reminded of the risks involved in working with mentally-ill offenders. As such, nurses assimilate a culture of risk and incorporate this notion into their practice. According to Chauvenet, Rostaing and Orlic (2008), the constant surveillance and rigid frameworks that forensic environments evoke force individuals (both patients and staff) to re-interpret the meaning of social interactions (Chauvenet, Rostaing & Orlic, 2008). Over time, representations of patients (or inmates) become polarized and the secure structure then becomes an environment where discourses of danger are omnipresent (Chauvenet, Rostaing & Orlic, 2008). Much like the results of this study, it is these polarized discourses of danger that come to limit therapeutic opportunities.

Fear:
The research results also emphasize the implication of fear in nurse-patient interactions and particularly how fear reinforces nurses' need to create a safe environment in order to practice (Jacob & Holmes, Forthcoming publication). A constant negotiation between space, bodies and security takes place where nurses are forced to scrutinize their actions (self-discipline) in order to avoid becoming victims of violence. In this way, the perceived risk of violence exerts a subtle governing influence over those who directly experience it, and those who believe they might" (Mason, 1999, p.122).

To this day, psychiatric nurses have always instituted rituals of protection such as removing personal articles and ward searches (Goffman, 1990; Morrison, 1990). By thinking in terms of prevention, nurses limit occurrences of violence, but also act on situations that have not yet happened. In this research, nurses defined three ways in which the threatening situation could be controlled:
1.) Interventions directed at oneself: gathering information about the patient and/or situation, and subsequently taking action to minimize victimization (talking in open spaces, doing rounds two-by-two, evaluating patients from a distance, etc.).
2.) Interventions directed at patients: forms of control aimed at patients, such as verbal de-escalation, PRN medication, using physical force, developing a privilege system, etc.
3.) Interventions directed at the environment: forms of control seeking to rearrange the environment to avoid becoming victims of violence, such as the use of cameras, controlling what is allowed on the units, staffing, etc.

In relation to security and the need to assure personal safety, the use of cameras was often described by participants as an ideal clinical tool. The use of cameras, however, was part of an ongoing debate regarding the use of security devices on the units. Participants expressed conflicting views regarding the positive and negative effects of cameras. On the one hand, the use of cameras fulfils an important role in securing boundaries between individuals (as well as providing a sense of safety), and on the other hand, it jeopardises therapeutic interactions by creating a distance between nurses and patients (Jacob & Holmes, Forthcoming publication).

Nevertheless, the deployment of strategies to minimize the possibility of becoming victims of violence and control potential threats remains part of a cultural script; that is, how potential risks are handled in the clinical setting is a process that is influenced by peers and organizational culture (Holmes, Perron & Guimond, 2007).

Othering:
In light of the risk of violence, participants described a process (Othering) that either facilitated or hindered therapeutic interventions (Jacob & Holmes, Forthcoming publication). Most importantly, exposure to patients' criminal history, as well as the inability to rationalize the patient's behaviours within a "sickness model", proved to be central elements in the nurses' ability to engage in therapeutic interactions with patients (Jacob & Holmes, Forthcoming publication).

In effect, mental representations of the forensic population are influenced by clinical practice. In some cases, "normalization" of the patient population (seeing the patient as a person) remained difficult. It is at this junction, where positive and negative representations collide, that nurses engage in a dual process of othering: inclusionary othering (self-identification with patients), and exclusionary othering (self-differentiation from patients) (Canales, 2000).

Consequently, participants described strategies (i.e. working in the moment, meeting the patient first, not reading the history, etc.) in which they try to eliminate the influence of the patient's history, or at least, decrease the effects that knowledge of the crimes may have on their judgment and practice. By doing so, nurses try to resort to an identification process (positive differentiation), wherein the individual requiring care does not become estranged to a point where care is no longer possible (negative differentiation).

Final Remarks

This research project suggests that the need for safety (both at the individual and collective levels) will always cast a dark shadow over the ideals of care. Working with an 'at risk' population proves to be difficult because this label tends to dictate the way in which nursing care is provided. As such, the implications of working under threat (real or perceived) proves to be a decisive factor in the practice of forensic psychiatric nursing, where nurses must adapt their care in relation to the need for personal safety and overall need for security.

Note:
This research was conducted in Canada and was funded by the Social Sciences and Humanities Research Council of Canada. A complete overview of the research results will be published in the Journal of Forensic Nursing (Jacob & Holmes, Forthcoming publication). Prior to data collection, Research Ethics Board (REB) approval was obtained.

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Educational goals

Overall, this research project suggests that the need for safety (both at the individual and collective levels) will always cast a dark shadow over the ideals of care. Working with an 'at risk' population proves to be difficult because this label tends to dictate the way in which nursing care is provided. As such, the implications of working under threat (real of perceived) proves to be a determining factor in forensic psychiatry, as nurses in this field must adapt their care in relation to the need for personal safety and overall security. In such a case, nurses must acknowledge and reflect on the effects of the patient's criminal history in the provision of care.

Correspondence

Mr Jean Daniel Jacob
University of Ottawa
451 Smyth Road
K1H8M5
Ottawa
Canada
+1 613.562.5800 ext.8421
jeandaniel.jacob@uottawa.ca

Locked doors: Increasing safety at what cost?

Paper

Anne-Marie Brown, Dawn Bollman, Patrick Griffith
Health Sciences Centre, Winnipeg, Canada

Abstract

Locking doors to psychiatric units has reportedly "flourished in recent years in many countries" (Cleary, Hunt, Walter, & Robertson, 2009, p644). The frequency of locking inpatient units in the UK for example has reportedly increased significantly in recent years despite a paucity of available research that examines the effect of this practice (Ashmore, 2008). Most commonly the rationale for locking inpatient units is for the safety of patients (Haglund, van der Meiden, von Knorring, von Essen, 2007). While units that were previously open presumably used other management techniques to ensure patient safety, literature suggests these strategies were not without limitations. Specifically, the use of close observation on open units is cited as one strategy that was not only labour intensive but potentially distressing for psychiatric patients (Cleary et al, 2009). Despite the increasing frequency of locked units little is known about the experience of these environments from the perspective of patients, their families or the staff on the unit. Locked units have been called prison like and restrictive and are reminiscent of former psychiatric institutions and asylums (Haglund et al., 2007). Such terms are synonymous with the paternalism that plagued historical psychiatric care and seem in direct contrast to the movement toward recovery and community focused care. A small number of publications were found that identify both advantages and disadvantages to locked units (Ashmore, 2008; Haglund et al., 2007; Haglund & Von Essen, 2005). One study that specifically aimed to gather the experiences of voluntary patients admitted to locked units concluded that several advantages and disadvantages exist. Advantages identified included the ability to keep unwanted visitors off units or providing relief for family members that their loved one was safe and secure (Haglund & von Essen, 2005). Voluntary patients in the study did however mention a greater number of disadvantages specifically confinement, a non-caring environment and concerns for visitors (Haglund & von Essen, 2005). In a second study that asked mental health nurses and nurse assistants their perceptions of locked units many of the same disadvantages and advantages were identified (Haglund et al., 2006). Once again a greater number of disadvantages were specified typically concerning patient experiences (Haglund et al., 2006). While the practice of locking inpatient unit doors is commonly introduced as a patient safety initiative there is evidence to suggest that there are times when mental health staff, enforce locked doors for alternative reasons. Specifically, mental health nurses have acknowledged that locking unit doors is at times initiated to protect themselves from liability or criticisms from their supervisors for not managing the safety risks inherent in acute psychiatric units (Ashmore, 2008). Given the potential disadvantages from the perspective of the patients and from mental health staff themselves combined with the issues of power and control, limitations on patient autonomy and threats to the ethical principles of nonmaleficence and justice, the practice of locking inpatient unit doors needs to be reviewed. Various stakeholders including mental health staff, health care leaders, patients and their families need to engage in discussions to attempt to balance the needs for safety with the rights of patients and their families.

Locked doors: Increasing safety at what cost?

Evidence informed practice is and has been for quite some time now, the expectation of all accredited health centres. Whether the language of the facility is evidence based practice or evidence informed practice the principles are the same – decisions that affect patient care should have support or proof for lack of a better word that the practice "integrates best research evidence with clinical expertise and patient values" (DiCenso, Guyatt, & Ciliska, 2005, p4). It has long been accepted "that's how we have always done it" reasoning is unacceptable. The near constant assertion is that health care professionals regardless of their discipline need to; use critical thinking, ask questions and be curious about their practice and the practice of their colleagues. In the growing body of patient safety literature it seems all too common when an adverse event has occurred the individuals involved might have questioned aspects of patient care but failed to state their wonderings out loud or stopped inquiring when a response was given, even when their underlying doubt remained. Furthermore, incidents have been reported in healthcare that are in some way tied to issues of communication resulting from the authority gradient that exists (Cronin, M.G., 2006). The assumption being that the power imbalance creates challenges to open communication between team members. Additionally, the culture of the organization itself may not tolerate or support challenges to those in leadership positions. These types of situations have resulted in patients being harmed, adverse outcomes being reported and the health care professionals involved being distressed over cases that on retrospect

seem to have been preventable – "if only". Despite this awareness and the shared learning that is occurring more and more in healthcare, decisions are made and practices prevail or change, at times without little if any dialogue about the how, why or what, that influenced them.

The Mental Health Context

Globally, acute mental health units have seen many changes since the days of asylums and the grand institutions and sanatoriums of the past. The number of beds has in many cases been reduced with a greater focus on community services, treatments such as ECT have become much more humane, and available medications are on the rise. Other changes however seem on the surface to look more like a stepping back than a moving forward. Housing issues for mental health patients is a vexing reality in many jurisdictions, low income and poverty are sadly all too common and funding dedicated solely to mental health research appears to remain far lower than most other chronic illnesses despite the current and rising predictions of the prevalence of mental illnesses. Of particular interest is the increasing number of publications, namely from the United Kingdom (UK) in the last decade, that have commented on and provided descriptive findings about, the rising number of locked or lockable units in psychiatry (Asmore, 2008; Cleary, Hunt, Walter, & Roberston, 2009; Van Der Merwe, Bowers, Jones, Simpson, & Haglund, 2009). In many cases locked units admit informal patients (Van Der Merwe et al., 2009), referred to as voluntary patients in the Canadian context. While the published literature to date helps to better understand the potential advantages and disadvantages of locked units (Adams, 2000; Ashmore, 2008; Haglund, van der Meiden, von Knorring and von Essen, 2007; Haglund, von Knorring & von Essen, 2006; Haglund & von Essen, 2005), it also raises interesting questions about the "rights" of a voluntary patient on a unit where the doors are locked.

In order to ethically and critically grapple with questions that surface when observations about this practice begin to be articulated, it seems necessary to attempt to understand the purpose, intent or goal of initiating locked doors on acute inpatient units. Based on the few publications that exist some educated assumptions can be made about the thinking that influences this practice. The ability to generalize these assumptions must however be questioned since the vast majority of publications on the topic come from Europe. Patients absconding or going absent without official leave (AWOL), increasing safety risks such as aggression, outside threats from visitors or access to illicit substances and the safety concerns related to acutely ill patients who may elope from the unit have all been listed as reasons for returning to the practice of locking the doors. On closer reading it seems that at least in some instances a single "critical incident" occurred which resulted in formal recommendations either from an internal process or external forces including politicians and the public at large (Adams, 2000; Voineskos, 1976). These recommendations in some instances appear to have initiated and perhaps in others forced the issue of locking unit doors. To be fair, there are many examples of public and political pressure resulting in positive improvements in the health care system. In the Canadian context major changes to our blood safety programs occurred after many patients were directly impacted by "tainted blood" (CBC news, 2006). Much of the safety improvements and process re-engineering that has occurred have been initiated and supported because of the often dramatic events that brought them to awareness. All this being said it is fundamentally important that we weigh the risks and benefits and closely examine the likelihood of a repeated incident before we unwittingly engage in "knee jerk" reactions and forge ahead on biased recommendations, regardless of how seemingly reputable the source. Take for example the case in which a potentially threatening individual is able to enter the unit and risks the safety of patients and staff, which is one of the advantages listed by patients and visitors (Haglund & von Essen, 2005) - keeping unwanted individuals out. We need to ask ourselves if this risk is unique to mental health and how common it is. Acute care hospitals are open 24 hours a day/7 days a week and provide care to all types of individuals with a variety of issues which can include violence. Do we assume that mental health patients are more vulnerable than all others? There are differences, but are we justified in reducing a patient's freedom based on scenarios that are a relatively uncommon occurrence.

Local Experience

In Manitoba, the largest acute care psychiatric facility has 80 available adult beds. In 2004, two of the units were locked, the forensic unit and the adult psychiatric intensive care unit (PICU). The other three units were "open" and were often described by staff on the locked units, particularly the PICU, as the transition units. Patients who were acutely ill and at risk for self harm or harm to others were often initially admitted to the PICU but were almost immediately made aware of the "open units" and encouraged to participate in their assessment has actively as possible so they could transition to an environment that allowed for more freedom. In 2005/2006, the "open" units were equipped to provide the option of being "lockable". The common understanding at the time was the option to lock the unit doors created a larger number of "secure" beds, potentially reducing delays in the emergency department and increased the overall safety of the building. Simultaneously, not unlike the situations described in the literature, an incident took place that

got public and political attention and the resulting pressure to take action may have created a "tipping point" of sorts. It did not seem to take long for the "option" of locking doors to be reduced to a program wide reality. All the previously open units are now locked 24 hours a day/7 days a week and have been for several years. Program staff routinely talk about the dramatically higher rates of acuity and the extra measure of safety provided by the locked doors. Conversely, there are also regular comments about the extra workload created by the need to always have a staff member able to lock and unlock the door. Legal liability concerns seem, in part, to fuel the belief that the doors are to remain locked for fear of an adverse event taking place that presumably would have been prevented had the doors not been open.

Local Questions

Recently questions have surfaced about the process of consultation. Despite the rather significant change in practice that occurred, there was reportedly no formal process to engage frontline staff, patients, families or consumer groups in the discussion of locking the unit doors. To date questions about how we arrived here, why we moved from "lockable" to permanently "locked", how the staff feel about locked doors, what do our patients think and how do their friends and family feel when they encounter the locked doors have not been formally explored using a research design. What impact does the decision to become permanently locked have on public education of mental health and illness, are we reinforcing the longstanding belief that mental health patients are dangerous and/or are we encouraging a false sense of security for patients and families by promoting locked doors as a strategy although no empirical evidence exists of its effectiveness (Van der Merwe, Bowers, Jones, Simpson & Haglund, 2009). Many years ago a personal friend and physician shared their belief that the number of malpractice cases in obstetrics may be related in part to a growing (albeit inaccurate) belief on the part of parents that childbirth was no longer risky. This physician postulated that improvements in technology, high quality and more easily accessible prenatal care was seen as having rectified many of the safety concerns of the past and women now mistakenly believed that they could be almost guaranteed a risk free birth and a healthy baby. Have we helped promote some of the same false beliefs in mental health by assuring the public, the patients and their loved ones that psychiatric hospitals are completely safe?

Future Research

To date published literature on the topic has offered up perspectives from patients and staff as well as the possible motivations and pressures to consider the practice of locked doors and an urging for researchers to look deeper into the topic. The published literature is woefully lacking in "evidence". Publications do not include quantitative research designs that investigate the effects of locked doors in inpatient psychiatry (van der Merwe, Bowers, Jones, Simpson & Haglund, 2009). Few North American studies have been published on the topic and the most recent Canadian academic contribution found during a recent search is dated 1976 (Voineskos, 1976). Perhaps most shocking from a local context is the seemingly absent commentary from the patient advocate and consumer groups. Ethics and justice have always been closely linked to mental health. Providing treatment to acutely ill psychiatric patients is in many ways fraught with ethical landmines that have in many cases been debated (not terribly effectively) in the media and other public arenas. Balancing the rights and wellbeing of patients and the safety and security of the public is a complicated but necessary dance. The decision to routinely limit an individual's freedom, particularly one who does not pose a risk to themselves or others but would benefit from hospitalization, should not be done without critical examination. This examination should include evidence of the impact of the practice. Adams (2000) concluded that "locked doors must not become the norm, but are a useful adjunct to improving the therapeutic care for patients on acute psychiatric wards on the rare occasions when they are necessary" (p328). In those cases where locked doors have become the standard we should be challenged to measure the impact of that action and share the findings.

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Educational goals
1. To explore the psychological impact of locked inpatient units on patients, families and staff.
2. To stimulate discussion on the ethical considerations of locking unit doors in adult acute mental health units.

Correspondence

Mrs Anne-Marie Brown
Health Sciences Centre
771 Bannatyne Ave
R3E 3N4
Winnipeg
Canada
+1 204 787-5088
abrown2@hsc.mb.ca

Workplace incivility: Impact on the staff nurse and organization including the financial ramifications

Paper

Patricia Lewis, Ann Malecha
Methodist Sugar Land Hospital, Sugar Land, Texas, USA

Aims

To investigate the influence of workplace incivility (WPI) on staff nurses and the organization including the role of the manager and impact on productivity and costs.

Research Questions

1. Is there a relationship between individual factors and workplace incivility?
2. Does years of experience impact workplace incivility?
3. Is there a relationship between organizational factors and workplace incivility in the hospital setting?
4. How does workplace incivility impact the productivity of staff nurses and costs to the organization?

Methods

Postal survey sent to 2,160 staff nurses in Texas (N=659 responded) included the Nursing Incivility Scale and Work Limitation Questionnaire. The Nursing Incivility Scale has five subscales: general environment, nurse, supervisor, physician, and patient/visitor. The Work Limitation Questionnaire (WLQ) has 4 subscales: time management, physical, mental/interpersonal, and output. The WLQ also calculates a Productivity Index. Both instruments possess excellent reliability.

Results

While 85% of the total sample (652) reported experiencing workplace incivility (WPI) in the past 12 months, staff nurses working in healthy work environments, defined as Magnet, Pathway to Excellence and/or Beacon Unit recognition, reported lower WPI scores compared to nurses working in the standard work environment ($p < 0.01$). WPI scores varied between type of unit. For example, the OR demonstrated higher WPI from the nurse, supervisor, and physician with the lowest WPI scores from the patient/visitor.

Nurses' perception of their manager's ability to handle WPI was negatively associated with WPI scores ($p < 0.001$). Furthermore, lost productivity, as a result of WPI, was calculated at ,581/nurse/year.

Demographic factors were not associated with WPI. However, past experience with WPI was associated with higher incivility scores. Years of experience was associated with WPI. Novice nurses had lower WPI scores for the nurse-to-nurse and nurse-to- supervisor scores than nurses with 3-5 and > 6 years of experience. Novice nurses experienced higher WPI scores for the patient/visitor subscale than nurses with 3-5 and > 6 years experience.

Conclusions

Not only does WPI exist at high rates, it is costly. Nursing and hospital leaders must be cognizant of this problem and implement measures to reduce and prevent workplace incivility. Civility matters!

Educational goals
1. To analyze the individual and organizational factors associated with workplace incivility in staff nurses.
2. To examine the impact of workplace incivility on productivity and its financial ramifications.

Correspondence

Mrs Patricia Lewis
Methodist Sugar Land Hospital
16655 Southwest Freeway
77479 Sugar Land
Texas
USA
+1 832 392 1412
pslewis@tmhs.org

The emotional impact of client aggression on staff who work with individuals with developmental disabilities

Paper

Jennifer Hensel, Yona Lunsky, Carolyn Dewa
Centre for Addiction and Mental Health, Toronto, Canada

Background

Individuals with developmental disabilities (DD) have deficits in communication, behaviour and social interaction which can often manifest in challenging behaviours including aggression towards self, others and property (1). These behaviours can be precipitated by any number of various causes including environmental stimuli, emotional reactions or physical pain and may at times be unpredictable or misunderstood by the direct care staff and others who work with these individuals. Unfortunately, the evidence for the use of antipsychotic medication to manage the behaviour is poor (2). There is a risk of resultant physical injury to clients or staff, but there is also the often less recognized risk of emotional stress to staff who are required to manage the behaviours.

Cumulative stress in the workplace can lead to burnout, a clinical syndrome characterized by emotional exhaustion (EE), depersonalization or detachment (DP) and a decreased sense of personal accomplishment (PA) secondary to long-term involvement in emotionally demanding situations. Health service workers are not uncommonly affected by burnout which can lead to more severe mental health problems including clinical depression, anxiety or substance use (3). A small number of studies have examined the relationship between client aggression and stress in direct care staff who work with individuals with DD and an association has been reported (4-6). There have been few studies of this kind in North America and there is a lack of large scale studies examining the role client aggression plays in staff burnout. Interestingly, overall burnout rates among this staff population have been found to be lower than comparable published normative values for human service workers (5). Some studies have shown that staff behavioural knowledge, attributions, emotional reactions and perceived self-efficacy in managing challenging behaviour may play a role in reducing stress and the development of burnout (7,8). A single small study also reported that these staff feel their work positively contributes to their lives (9) and this may be an additional mediating factor.

The first aim of this study was to examine the experience of aggressive behaviour among a large population of direct care staff who work primarily with adults with DD in the province of Ontario, Canada. Secondly, this study measured burnout rates in this population and investigated several of the positive and potentially protective factors that have previously been identified.

Methods

For the purposes of this study, a survey was developed and disseminated on-line or in hardcopy to all agency-affiliated direct care staff in Ontario's DD sector. Study participation was voluntary and anonymous. Survey questions addressed demographics, frequency and severity of aggression, and burnout using the well validated human services edition of the Maslach Burnout Inventory (MBI). The surveys also assessed perceived self-efficacy in terms of dealing with aggression, and positive contributions (ratings of how working with clients with DD has a positive impact on life) using validated scales developed by researchers in the UK.

Data were analyzed using descriptive statistics to examine relationships between aggression and burnout. Research ethics approval was obtained from the Centre for Addiction and Mental Health Research Ethics Board prior to initiation of the project.

Results

Survey respondents (n=926) included representatives from all regions of the province. Respondents were 82% female with a mean age of 40 ± 11 years (range 20 to 65 years). Sixty-seven percent of staff were

married or living common-law. Twelve percent of staff were foreign-born although there was a significant association by region with Toronto (Ontario's most multicultural city) having more foreign-born staff than any other region (35%; $x2(8)=47.8$, p<0.001). Ninety-one percent of staff were working full-time hours (more than 35 hours/week). The respondents were fairly experienced with 74% having more than 5 years of experience in the sector, and nearly 30% having more than 20 years of experience.

In terms of frequency of client aggression experienced in the previous 6 months, 74% of workers experienced aggressive behaviour at least 1-3 times per month, and 26% reported experiencing it almost every day. For 40 and 33% of staff verbal aggression directed at themselves or towards others was the most severe form of aggression they had experienced in the previous six months. Fourty-seven percent of staff reported experiencing physical aggression directed toward themselves which resulted in physical injury for 16% of them. Fifty-two percent witnessed physical aggression directed towards someone else other than the client or themselves and 20% witnessed resultant injury. Client self-injurious behaviour was experienced by 77% of staff and 40% saw this lead to physical injury to the client. A comparable 73% witnessed property aggression and 40% again saw this lead to injury or property damage. On average the overall perceived severity of aggression was rated as 53 out of 100 with roughly equal percentages in each quartile. While full-time staff reported more frequent aggression, severity ratings did not differ across hours worked. Years of experience also had no impact on frequency or severity of aggression. Only 6% of staff had missed time from work because of a physical injury sustained secondary to client aggression.

Overall mean burnout scores were 18.7 (EE), 4.7 (DP) and 36.9 (PA) and were significantly more favourable than published norms for social service workers. Regardless, a proportion of staff did score in the high range for EE (24%), DP (7%) and PA (18%).

In terms of the positive staff factors evaluated in this study, 80% of staff rated themselves as good or excellent with regards to their own perceived self-efficacy in managing challenging behaviour. Thirty six percent of staff scored high in terms of the positive contributions they receive from their work while an additional 60% had moderate scores.

Discussion

This study represents a large scale North American provincial assessment of the client aggression and challenging behaviour experienced by direct care staff in the developmental disabilities sector with a focus on the physical and emotional impact it has on them. The findings here highlight that client aggression is a common occurrence and for one quarter of staff it is something they deal with on a near daily basis. The consequences of this cumulative stress have also been elicited. Although burnout scores in this population were lower than published norms as has been previously reported (5), a group of workers are still substantially affected. Moreover, although few staff actually miss time from work due to injury, many others continue to work despite suffering associated stress. This also has a large impact on clients in terms of continuity and quality of care which, if disrupted, can exacerbate difficult behaviour.

Given that burnout develops in the setting of ongoing emotional strain and without intervention can lead to more serious and impairing mental health problems (3), there is a proportion of these staff who would be considered at risk for this progression. The population surveyed in this study were very experienced staff which may also suggest that those who burn out early leave the profession. The identification and implementation of useful and effective interventions directed at improving stress management and preventing the development of burnout in these staff is therefore needed. The results here suggest that the positive contributions staff receive from their work and their own perceptions about their ability to manage difficult behaviours may be areas worth fostering.

This study is limited by the voluntary participation of staff and the results reported may not be representative of the total population. In addition, it is a cross-sectional assessment and data speak to associations only. Further research will need to further investigate the relationship between client aggression and burnout in this population and explore possible interventions directed at improving staff well-being.

Acknowledgements

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Educational goals
1. To inform and raise awareness of the frequency and severity of client aggression experienced by direct care staff who work with individuals with developmental disabilities.
2. To highlight the impact of exposure to aggression on emotional well-being and burnout among direct care staff.

Correspondence

Mrs Jennifer Hensel
Centre for Addiction and Mental Health
33 Russell St
M5S2S1
Toronto
Canada
+1 416 535 8501
jennifer.hensel@utoronto.ca

Self harm: Violence on the body, impact on staff

Workshop

Wendy McIntosh
Davaar Consultancy, Brisbane, Australia

This workshop explores the impact for staff when working with clients who self harm. The act of self harm can be viewed as a violation on the body and as a tension reduction strategy. Staff can experience vicarious trauma when witnessing and experiencing the self harm of clients.

It is important that staff recognise the variety of reasons for self harming behaviour especially the link between childhood abuse (sexual, physical, emotional assault and neglect and abandonment).

In many ways what staff witness in the self harm behaviour is the violence that was perpetrated on clients when they were children. As such it is important that the witnessing is respectful and validating, rather than punishing which potentially perpetrates further assaults on the emotional experience of the client.

Using a number of interactive techniques from psychodrama the facilitator will engage participants to:
• explore their reactions to clients who self harm,
• build a broad range of creative interventions that they can use with clients who self harm,
• understand the link between the limbic system and self harm,
• understand the story of underlying violence in self harm behaviour.

Educational goals
• To engage participants in a dialogue about the meaning of self harm in the context of violence.
• To understanding how health systems may create further acts of self harm in clients.
• To develop a broad range of interventions that can be used with clients who self harm.

Correspondence

Mrs Wendy McIntosh
Davaar Consultancy Training & Development
PO Box 322, Wellers Hill
4121
Brisbane
Australia
+61 411 385 573
whmcintosh@bigpond.com

Direct Observational Coding of Staff who are the victims of assault in a psychiatric hospital

Paper

Will Newbill, Dean Marth, James Coleman, Anthony Menditto, Sarah Carson, Niels Beck
Robert Wood Johnson Medical School/UBHC/UMDNJ, Piscataway, USA

Introduction/Background

In inpatient facilities, staff are often assaulted by residents with serious mental illnesses. In the past, research focused largely on demographic and diagnostic characteristics of those who committed violent acts[1]. While the resulting knowledge impacted risk assessment, the variables investigated could not directly inform risk management strategies, because the constructs used were fixed and/or resided in the past. For example, young males with histories of violence and substance abuse are more likely to be aggressive, but age, sex, and past actions are all beyond the influence of clinicians.

The past few decades have brought increasing awareness of the importance of dynamic risk factors such as situational influences on violent acts[2]. A number of surveys on the perceived cause of assaults from the perspective of both staff and consumers have been published [3-9].

Staff and residents of inpatient settings tend to disagree on the proximal causes of assaults, with staff members most frequently attributing assaults to internal stimuli or psychosis [4-5, 10-11] and residents most frequently pointing to reality-based aversive interactions with staff as a trigger. Across various studies, residents describe three major classes of aversive interactions: activity demand (when staff try to get residents to do something that they don't want to do), limit setting (when staff try to get residents to stop doing something that they want to keep doing), and denial of request (when staff say no to a resident's request for goods, privileges, or assistance)[4, 9].

Interpretation of these findings, however, is complicated by over-reliance on self report. The correspondence hypothesis, or the proposal that there is a 1-to-1 relationship between verbal report and the actual state of affairs in the world, subsumes two implicit assumptions: The reporter is both 1) willing to report accurately and 2) able to report accurately. In situations where violent conflict has occurred, there is reason to doubt the willingness and ability of both staff and residents to report accurately. In effect, when asked who is responsible for an assault, each party points to the other. This problem has been recognized for years, and studies have attempted to limit the impact of errorful, biased self report by utilizing standardized reporting forms[12], cameras[7], or third party (researcher) inferences about the trigger of assaults[13]. Ultimately, observational research provides the best opportunity for examining staff-resident interactions objectively, leading many researchers to call specifically for such studies[8, 14-17].

For over 20 years, non-participant observations of staff-patient interactions have been collected at Fulton State Hospital. This data has primarily been used to assess and improve fidelity to the empirically-supported Social Learning Program model[18-20]. Within the Social Learning Program (SLP), all levels of staff are expected to engage in certain kinds of interactions with patients and to refrain from engaging in other kinds of interactions. Among the 21 categories capturing staff responses to patient behavior are a number of categories that indicate occurrence of aversive staff-patient interactions such as limit setting, activity demand, and denial of requests.

The 10 years of data collected from 1997-2007 add up to over 26,000 person-hours of observed staff-resident interaction. The existence of what is undoubtedly the largest collection of direct observational coding of staff-resident interactions in the world allows us to determine if staff who have been assaulted engage in higher rates of aversive interaction than staff who have not been assaulted. If no differences are found, then the validity of resident reports regarding aversive interactions must be called into question, thus exposing residents' claims to possible falsification. While the existence of higher rates of aversive interactions among staff who have been assaulted cannot, in isolation, establish the validity of resident claims, such a finding would justify further research, and possible development of interventions that target changes in staff-resident interactions to reduce assaults.

Methods

During the study period, a total of 805 staff members worked 3 or more months on one of six SLP units, a length of time sufficient to ensure representative data on staff-resident interactions could be gathered. All of these individuals were included in the study. The average age of staff members was 43.2 years (SD = 12.8) at the end of the study period. Average length of employment was 8.9 years (SD = 9.5). The sample contained 59.8 % females (n = 481) and 40.2 % males (n = 324).

The residents on Social Learning Programs are best characterized by the criteria governing admission to those units. These admission criteria are as follows: The presence of functional psychosis of a severe and persistent nature; primary diagnosis is not a personality disorder; person has been continuously hospitalized for one year or more or has had repeated hospitalizations with failed community placements; the person has severe deficits in functioning in the areas of self-care skills, social skills, and/or instrumental role performance; and/or the person exhibits high rates of bizarre behavior.

Measures

The Staff-Resident Interaction Chronograph (SRIC) is an objective measure of the staff activity and staff-resident interactions that comprise treatment programs on psychiatric inpatient units. SRIC data are collected by highly-trained, professional, independent, and noninteractive observers who record staff members' verbal and nonverbal responses to the behavior of residents over the entire duration of a 10-minute observation period. Multiple 10-consecutive-minute observations are collected over time, based on a stratified hourly sampling schedule to ensure representative coverage of all staff and activities in proportion to their actual presence in the program over a one-week period.

Sampling of observation occasions occurs over all hours that residents are scheduled to be awake, resulting in 10-16 observation sessions, on average, per day on each unit. For each staff-resident interaction the 5 X 21 SRIC matrix classifies resident functioning in five global categories (Appropriate; Inappropriate Failure; Inappropriate Psychotic; Requests; and Neutral). Staff responses to resident behavior are coded into one of 21 low-inference, detailed categories (Positive and Negative Verbal, Nonverbal, Nonsocial, Statement, Prompt, and Group Reference; Reflect/Clarify; Suggest Alternatives; Instruct/Demonstrate; Doing With; Doing For; Physical Force; Ignore/No Response; Announce; and Attend/Record/Observe).

The data generated by the SRIC are reported in a metric of the average instances of a specific class of staff response to a category of resident behavior, per hour. For example, a score of 10.00 on "Positive-Verbal to Appropriate" would indicate that the staff member in question responds to appropriate resident behavior with verbal praise an average of 10.00 times an hour.

The reliability and validity of the SRIC is well documented [21], with intraclass correlation coefficients (omega squares) over all codes, categories, and indices averaging about .96. The first author of this paper, who has used SRIC reports for 7 years to assess and improve fidelity on two treatment units, identified, with assistance from the second author, those interactive codes on the SRIC that captured limit setting, activity demand, and denial of requests. These codes were then brought to a panel of experts at FSH where they were vetted for validity. Nine codes were identified by consensus, a priori, as consistent with the constructs of interest: limit setting, activity demand, and denial of requests.

The nine interactive codes included some combination of one of the following staff responses to one of the kinds of resident behaviors described below: A Negative Verbal response (NV) occurs when a staff member responds to a resident behavior with reprimands, derogatory remarks, exclamations, statements relating to the inappropriateness of the behavior in question, or (in the case of a resident request) by saying "No." Positive Statements (PS) include commands such as, "You need to get out of bed and go take your medication." Negative Non-Social (NNS) staff behavior is coded when a staff member removes desirable objects or goods from the possession of a resident, or actively limits resident access to a desirable good or privilege. The kind of resident behaviors to which staff may respond include Appropriate (AP) resident behavior, (behavior that would be regarded as adaptive or normative in a typical American community); Inappropriate Failure (IF) (a resident fails to perform behaviors that would be appropriate given the demands of time, place, and circumstance) (e.g., failing to wear clothes in a public space); Inappropriate Psychotic (IP) (behaviors that are always considered maladaptive, regardless of time, place, and circumstance) (e.g., screaming in response to unseen others) and Requests (R) (verbal or non-verbal indications of a desire for help, services, goods, or privileges from staff).

Assault Identification:

Assaults were identified using an event-triggered recording form called the "Incident and Injury" report. Hospital policy regarding completion of this form dictates that "any employee who observes, discovers, is

informed of, or is involved in an incident shall initiate the 'report' as soon as possible after providing for any immediate needs of those involved." In this study, assaults were counted if a resident intentionally attempted to inflict physical harm on a staff person. Injuries that occurred accidentally were not included. Only one incident form was completed for each aggressive event.

Results

An experiment-wise Bonferroni correction was applied, leading to a critical p value of .0056. The distribution of the hourly rates of each of the nine interactive codes was both skewed and kurtotic. This was expected, as rate scores are rarely distributed normally. Following square root transformations, all of the variables' distributions were within acceptable limits, except for Negative Non-Social staff responses to Appropriate patient behavior. This reflected the fact that it was rare for a staff person to take away some desirable good from a patient who was engaged in appropriate behavior – as a result, there were a large number of staff who had hourly rates at or near zero for this variable. Interpretation of significance for NNS-AP must take into account the fact that assumptions of the t-test had been violated.

Overall rates of total interaction were not significantly different between assaulted (198.9 interactions/ hour) and nonassaulted staff (209.4 interactions/hour). This rules out the possibility that staff who were assaulted more frequently were at higher risk solely because they spent more time "on the floor." Significant differences were found in eight of the nine variables examined. Only one variable, NNS-AP, was not significant at the corrected p-value cutoff. In all cases, the group of staff members who had been assaulted engaged in higher rates of aversive interactions than staff who had not been assaulted.

Conclusions

The results of this study are consistent with resident reports that aversive interactions trigger assaults on staff. The study design does not allow for causal interpretations of the data. It is possible, for example, that staff in this study were assaulted first, and as a result went on to have a greater number of aversive interactions with residents. Our findings, however, are consistent with those observed by some other authors who have avoided reliance upon self-report while investigating situational triggers of violence in inpatient settings. For example, after reviewing all available medical records, Quanbeck et al.[13] found that "impulsive" motivation was responsible for the majority of assaults on staff. They describe impulsive motivation as occurring after patients are "directed or denied," which appears consistent with the constructs of activity demand and limit-setting/denial of requests, respectively, as used in this study.

If aversive interactions do increase risk of assault, new interventions could be added to existing approaches to aggression management. On the staff side, de-escalation techniques might be augmented by training in non-escalation approaches to limit setting, activity demand, and denial of requests. After all, the easiest fire to put out is one that has never been started. Lancee and colleagues have done important work in identifying limit-setting styles that don't increase anger.[22] In addition, residents might be trained specifically in interpersonal effectiveness and management of strong emotions. Both parties would probably benefit from identifying specific situations as involving increased risk of anger and assault – particularly activity demand, limit setting and denial of requests. These may prove to be occasions, then, where intentional recruitment and utilization of skills may prove salubrious.

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Educational goals
1. To identify the factors that staff and patients describe as triggering assaults, how staff and patients differ in their opinions, and list the problems involved in taking self-report as factual evidence
2. To understand whether direct observational coding supports staff or consumer report.

Correspondence

Mr Will Newbill
Robert Wood Johnson Medical School/UBHC/UMDNJ
151 Centennial Ave.
08854
Piscataway
USA
+ 1 732 235 2864
newbilwa@umdnj.edu

A rare but dangerous complication of physical restraint: Asphyxiation

Poster

Rolf Wynn, Trygve Nissen, Per Rørvik, Laila Haugslett, Trude Wynn
University of Tromsø, Tromsø, Norway

Background

Physical restraint is a last resort measure that is used in psychiatric institutions in many countries to contain and calm aggressive or violent patients. While this can be an effective measure to control a dangerous situation, prior literature has shown that both patients and staff may get harmed during its implementation. In this study, we present and discuss a serious and rare complication of physical restraint: the asphyxiation of the patient.

Material and methods

We conducted a review of literature describing asphyxiation during physical restraint.

Results

There have been reports of some patients having suffered asphyxiation during physical restraint. The mechanism causing the asphyxiation has been discussed. Some believe that the positioning of the patient is crucial, and that patients that are kept in a prone position or in a basket hold position are more likely to be suffocated. Possible mechanisms are an increased intra-abdominal pressure and restricted thoracic cage expansion. Other factors that may contribute to respiratory problems while in restraint can be hyperthermia, physiological stress and prior illicit drug use.

Conclusion

In very rare cases, physical restraint may result in asphyxia.

Educational goals
1. To learn about a very rare but important detrimental outcome of physical restraint, the asphyxiation of the patient.

Correspondence

Mr Rolf Wynn
University of Tromsø
UNN-Åsgård
N-9291
Tromsø
Norway
+47 776 69506
rolf.wynn@gmail.com

An examination of nursing students' experiences as victims of physical and sexual violence

Paper

Raleigh Blasdell, Alison Blasdell
University of South Florida at Tampa, Tampa, FL, USA

While discussing the role of nurses in screening and caring for women who had been the victims of physical or sexual violence, we discovered that many of the nursing students in our community college had themselves been victims of violence. We became interested in exploring this issue to determine the extent of victimization and the students' attitudes or preconceived ideas about physical and sexual violence towards women, including intimate partner violence (IPV). A better understanding of this phenomenon would assist us in supporting our students and in designing a program that would best prepare them for entering the health care sector where they would be caring for victims or known perpetrators of violence. Their own experiences as victims might also affect their feelings of safety in the health care setting. The purpose of the following study was, therefore, 1) to examine nursing students as victims of childhood and adult physical and sexual violence, 2) to examine nursing students' attitudes about domestic violence, and 3) to ascertain their need for training in caring for victims of violence.

The sample for this study consisted of all female nursing students enrolled in an associate degree nursing program at a Midwestern community college. 157 students anonymously completed a 22-item questionnaire that measured childhood exposure to domestic violence, beliefs regarding women involved in relationships in which battering occurs, and their personal experiences of violent victimization. Initial data analysis revealed: 25% of students (as children) witnessed a female parent being abused by a partner; 65% experienced physical violence themselves before the age of 18; 20% experienced sexual violence before age 18; 35% experienced physical violence by a partner since age 18; 16% experienced sexual violence by an intimate partner since age 18. Regarding attitudes, 21% felt that "battered women can always leave the relationship," 20% felt that "a man who batters has probably been provoked by something the woman said," and 3% felt "women who stay in battering relationships like to be treated that way." Finally, 38% of students felt the need for additional training on IPV and care of victims of physical and sexual violence. Data analysis continues with the remaining 13 items.

Nurses, by virtue of their relationship with patients, are in a key position to screen women for violence and make referrals to appropriate agencies/resources, thereby empowering women living with violence. This study suggests, however, that some students still adhere to myths regarding battering. Furthermore, these nursing students experienced a higher incidence of victimization than the literature suggests for women in the USA. Finally, preliminary analyses suggest that some victims of violence question their ability to provide adequate health care to perpetrators of violence. These findings should be of concern to nurse educators and administrators in the health care sector. The authors plan on expanding this study to include associate and baccalaureate nursing students in multiple college and university settings.

Educational goals
1. To recognize the extent to which nurses may have been victims of violence.
2. To understand the potential impact that a nurse's experience as a victim of violence might have on her ability to care for other victims or perpetrators of violence.

Correspondence

Mrs Raleigh Blasdell
University of South Florida at Tampa
4202 East Fowler, SOC 107
33620
Tampa, FL
USA
+1 727 873 4959
rblasdel@mail.usf.edu

Professional Quality of Life and Symptoms of PTSD in adult and child- and adolescent mental care units

Poster

Christian Lauvrud, Kåre Nonstad, Anne Mari Undheim, Tom Palmstierna
St. Olavs University Hospital, Forensic Department Brøset, Trondheim, Norway

Background

In child- and adolescence mental health care institutions, a high level of aggression is common. Being forced to manage and treat young violent patients often provokes adverse feelings and negative workplace experience which often causes feelings of fear, anxiety and other emotionally sequelae. This is reported to interfere with the therapeutic or professional capacity. Little research has examined the impact of exposure to aggression in working within child and adolescent inpatient units. This seems to be a paradox since the therapeutic relationship is deemed the most powerful 'tool-of-the-trade' within child- and adolescence mental health care. The authors have explored the same questions in a Norwegian high security hospital, and will continue to do so, using an electronic survey method. The preliminary data from a security hospital is presented, together with a description of the methods and objectives for the child- and adolescent mental health worker study.

Objective

The aim of this study is to explore the relationships between, and occurrence of, job satisfaction, burnout and symptoms of post traumatic stress among milieu therapists working in child- and adolescent mental health care where there is a high frequency of violence. This happens in parallel with a replication of earlier studies on a high security ward, and the results will be used to illuminate each other in the poster. A third objective is to compare the forthcoming results with a Swiss study, towards which a third questionnaire is introduced.

Methods

The study will be cross-sectional using three questionnaires. Post Traumatic Check List - Civilian version (PCL-C), the Impact of Events Scale- Revised (IES-R) and Professional Quality of Life Scale (ProQoL). The survey is to be administered anonymously among milieu therapists at two child- and adolescent mental health care units, and to all ward staff at a Norwegian high Security Hospital.

Educational goals
1. To expand the knowledge of the impact of working in a high violence environment while providing care (individual level).
2. To provide information needed to plan and take care of Health, milieu and security factors in mental health services (systemic/organizational level).

Correspondence

Mr Christian Lauvrud
St. Olavs University Hospital
Forensic Department Brøset
Centre for Research and Education in Forensic Psychiatry
P.O. 1805 Lade
7440
Trondheim
Norway
+47 728 235 59
christian.lauvrud@ntnu.no

The psychological impact of aggression on a sample of psychiatric nurses in Germany and Switzerland

Paper

Ian Needham, Fritz Frauenfelder, Cornelia Gianni, Jürg Dinkel, Ruth Hatcher
Centre of Psychiatry Rheinau, Rheinau, Switzerland

Background

Aggression and violence can have severe effects on nursing personnel which may include somatic injury and psychological sequelae (Needham, Abderhalden, Halfens, Fischer, & Dassen, 2005). Previous studies from the psychiatric and forensic nursing domains – in which patient aggression towards staff is a prominent problem – highlight the psychological stress experienced by nurses but often offer an ambiguous picture. One line of inquiry has been research on Post Traumatic Stress Disorder (PTSD) in nurses. Robinson et al. (2003) reported that 1.4% of psychiatric nurses fulfilled the PTSD criteria and that a further 35% showed at least one PTSD symptom. Richter and Berger (2006) reported in a study on German nurses that 17% of psychiatric nurses fulfilled the PTSD criteria after being subjected to violent assault by a patient. By contrast, a study on a Norwegian sample of 70 forensic psychiatric nurses (Lauvrud, Nonstad, & Palmstierna, 2009) found that none of the respondents fulfilled the criteria for full PTSD but three persons (4.3%) reported at least one symptom occurring moderately.

Other indicators of psychological stress are Compassion Satisfaction, Burnout, and Compassion Fatigue as operationalised by the Professional Quality of Life Scale (ProQOL) (Hudnall Stamm, 2005). In a recent Norwegian study (Lauvrud, et al., 2009) the Professional Quality of Life Scale (ProQOL) was used to assess levels of psychological stress on forensic psychiatric nurses on four wards. The study findings show that the mean scores were lower than standard scores – Compassion Satisfaction = 33, Burnout = 17.3, and Compassion Fatigue = 5.8 – as compared with the norm values of 37, 23, and 13 respectively. A Burnout study by Happell et al. (2003) revealed that nurses working in forensic psychiatry have lower levels of Burnout on all three dimensions of the Maslach Burnout Inventory than nurses working in mainstream psychiatric settings.

Study aim

Against this background of ambiguous findings this study set out to ascertain psychiatric nurses' levels of stress associated with aggressive incidents.

Material and methods

Using convenience sampling psychiatric nurses working two forensic hospitals (n = 172) and from an acute mainstream psychiatric setting (n = 31) were recruited. The Swiss forensic psychiatric nurses were recruited from the largest Forensic Psychiatric Hospital in the country. The German forensic psychiatric nurses were recruited form a large forensic psychiatric hospital in Bavaria. The nurses from the acute psychiatric setting were recruited from a Swiss psychiatric hospital in the same area as the Swiss forensic site. Fifty four nurses reported aggressive incidents which were coded by two independent raters (IN and FF).

The psychological impact of aggression was measured using the revised Impact of Events Scale (IES-R) (Weiss & Marmar, 1997) and the Professional Quality of Life Scale (ProQOL) (Hudnall Stamm, 2005). The IES-R measures three dimension of PTSD (Avoidance, Intrusion, and Hyper-Arousal) from which a total score of maximum 88 points can be computed over all three subscales. A score of 33 points or more – as suggested by Creamer et al. (2003) – was taken to indicate a fully fledged PTSD. The ProQOL measures the following dimensions: Compassion satisfaction (the pleasure derived from helping others), Burnout (the "feelings of hopelessness and difficulties in dealing with work or in doing your job effectively"

(Hudnall Stamm, 2009, p.13), and Compassion fatigue (the "the natural, consequent behaviours and emotions resulting from knowledge about a traumatising event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatised or suffering person" (Figley, 1995, p.10)).

Results

Fifty four registered psychiatric nurses – nine (16.7) from acute psychiatric and 45 (83.3%) from forensic settings – reported an aggressive incident as burdensome. Forty two percent were female and almost 75% of the nurses who reported an aggressive incident are aged between 30 and 50 years with an average tenure in nursing of just over 18 years (±8.25 years). On average the aggressive incident occurred 5.5 years ago with a range of 1 to 309 months since the incident. The aggressive incidents comprised verbal (21) and physical (30) hostility and hostage taking (3) but excluded auto aggressive behaviour of patients. The seven incidents which included the use of knives, biting or strangling were coded as dangerous. Eight injuries were reported including stabs, bites, bleeding and – in one extreme case – a life threatening injury. Five incidents of vicarious aggression (i.e. having witnessed an act of aggression in which one was not the object of aggression) were reported. The PTSD scores of nurses who had been aggressed in a dangerous manner (Mann-Whitney-U = 155, p = .802) or nurses having experienced injury (Mann-Whitney-U = 202, p = .991) did not significantly differ from those of nurses who had not endured such experiences. No statistically significant differences were found across settings (acute and forensic psychiatry) or countries.

The overall score of the IES-R of the sample was 23.46 (±15.26) out of a possible maximum score of 88 points and the scores for the subscales Avoidance, Intrusion, and Hyper-Arousal were 8.91 (±.6.29), 8.54 (±.6.39), and 6.00 (±.5.18) respectively. Figure 1 displays the summed scores of the individual nurses and demonstrates that 15 persons (28%) had an IES-R score of 33 points or more indicating a PTSD.

Figure 1: Individual IES-R scores (min = 0, max = 88 points)
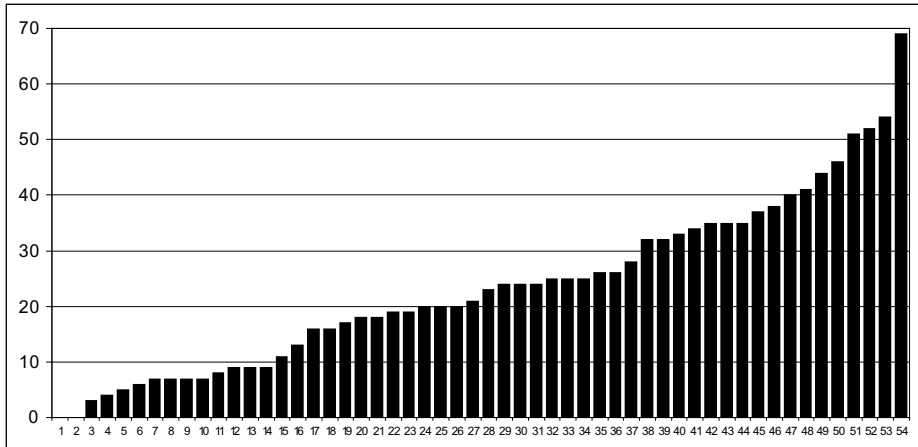
The scores for the ProQOL subscales were 30.39 (±7.43) for Compassion Satisfaction, 11.83 (±4.66) for Compassion Fatigue, and 20.78 (±4.05) for Burnout. No statistically significant differences were found across settings (acute and forensic psychiatry) or countries. Of the 54 nurses 38 (70.4%) showed a low level of Compassion Satisfaction (N = 34) or a high level of Compassion Fatigue (n =6) when applying the cut offs suggested by Hudnall Stamm (2005). None of the nurses demonstrated a high Burnout level. A logistic regression with low Compassion Satisfaction or high Compassion Fatigue as the predictor variable gave rise to an overall predictive power of 81.5% This model demonstrates that the odds of suffering low Compassion Satisfaction or high Compassion Fatigue are associated with a lesser proportion of direct patient contacts (OR=.90), are negatively related to tenure in the psychiatric nursing profession (OR=.98) but positively related to the years of experience in present workplace setting (OR=1.02).

Discussion

This study set out to ascertain psychiatric nurses' levels of stress associated with aggressive incidents. Seven incidents (13%) reported by the nurses were of a dangerous nature and eight incidents (15%)

resulted in injuries including one life threatening injury. Interestingly, the PTSD levels of these nurses proved not significantly different from nurses having reported less serious incidents. This finding may indicate that nurses' responses to aggressive incidents are highly individual.

The proportion of nurses enduring a PTSD (28%) is much higher than in comparable studies (Lauvrud, et al., 2009; Richter & Berger, 2006; Robinson, et al., 2003). This alarming finding indicates that in a nursing team of 16 persons almost five nurses suffer from a fully fledged PTSD. The most extreme difference exists between the Norwegian study with a zero PTSD rate versus 28% in the present sample. One tentative explanation for this may lie in the very favourable staffing resources in the Norwegian setting (Lauvrud, et al., 2009). Additionally, it can not be ruled out that the invitation to report a stressful incident may have led to an inflated proportion of PTSD in the present study by way of an "invocation" bias. However, the fact that the reported aggressive incident occurred on average 5.5 years ago seems to indicate a heavy impact it had on the nurses.

The levels of Compassion Satisfaction and Compassion Fatigue of the nurses in the present sample are more adverse than those found in the Norwegian study in all three dimensions (Compassion Satisfaction = 30.4 versus 33; Compassion Fatigue = 11.8 versus 5.8; Burnout = 20.8 versus 17.3) and may be attributable to differences in staffing resources or other structural aspects nursing (e.g. education or supervision) in the different areas.

The logistic regression on nurses with low Compassion Satisfaction or high Compassion Fatigue revealed some noteworthy findings. The analysis revealed that a lesser proportion of time in direct patient contact is indicative of adverse scores on Compassion Satisfaction or Compassion Fatigue. Possibly the psychological stress is not the result of direct patient contact but the consequence. The analysis also suggests that whilst tenure in the profession of psychiatric nurse appears to be protective of psychological stress (OR=.900) longer durations in the present workplace render nurses more susceptible to psychological stress (OR=1.02). Lauvrud et al. (2009) raise the question as to whether a maximum tenure in forensic nursing may be meaningful. Accordingly one could pose the same question on the sample under scrutiny in the present study. However, – on a methodological note – it must be borne in mind that the proximity of the Odds Ratios around 1 indicates a rather weak predictive capacity of the model.

Various limitations pertain to this study. As the study used a convenience sample the findings may not be representative of the population. Secondly, answering bias favouring the less psychologically impacted cannot be ruled out and it is possible that heavily impacted nurses are no longer in the profession. Finally, given the cross sectional study design it is not possible to infer any causal relationships between psychological stress and the stressful aggressive situations reported. It is possible that the psychological stress existed prior to the incident.

Conclusions

The higher rates of psychological stress were found in this study than in comparable samples. This indicates that a larger proportion of nurses than expected suffer psychological stress associated with patient aggression. This could also infer that the quality of work with psychiatric patients is under jeopardy. Furthermore it seems, that nurses' respond differently to similar types of burdensome situations. The study findings do help to clarify the ambiguous results found in previous studies. Further studies could address the function of situational factors associated with psychological stress and nurses' possible resilience factors in handling aggressive situations.

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Correspondence

Mr Ian Needham
Centre of Psychiatry Rheinau
Postfach
8462
Rheinau
Switzerland
+41 52 304 94 90
needham@bluewin.ch

Chapter 5 - Methodological issues regarding researching violence in the health sector

Population-based surveillance of workplace conflict in a large hospital system

Paper

Judith Arnetz, Deanna Aranyos, Mark Upfal
Wayne State University School of Medicine, Detroit, Michigan, USA

Introduction

Workplace violence in general hospitals is a serious occupational hazard.[1-3] Certain environments, such as emergency departments[4-5] are at increased risk, especially for Type II violence, i.e., from patients and patient visitors.[6] Nursing staff is consistently identified as being at increased risk for Type II violence compared to other professional groups.[2,7-9] In recent years, Type III, or worker-on-worker violence, including workplace conflict, among healthcare employees has received increased attention, with reports of "horizontal violence" among nurses[10-11] and disruptive behavior among both physicians and nurses.[12] Thus, violence in hospitals is not always physical in nature but encompasses a broad range of "workplace conflict" behaviors that may significantly affect the health and safety of employees.[13-14] There is growing evidence that the psychological trauma, even among victims of non-physical workplace violence, has negative effects on work performance and the quality of care provided.[13,15] Moreover, even when such events do not result in any form of trauma, they are still disruptive, with the potential to negatively impact productivity, efficiency, and the efficacy of care.[12]

The need for population-based violence surveillance in hospitals

Comprehensive surveillance of violent events is a prerequisite for accurate epidemiological analyses of risk factors, injury trends, and the development of violence prevention programs in hospitals.[16] However, there are two main barriers to effective surveillance: (1) Underreporting of violent events, especially workplace conflict, that does not result in physical injury or time away from work;[17] and (2) a lack of systems for continuous monitoring of those events. As a result, we lack needed empirical data, especially on the less severe, but more common, violent events.[17] Many hospitals today only collect and review data on violent events on an incident-by-incident or case basis. There is a need for population-based surveillance that would provide hospital administrators with facts on rates of violence exposure based on estimates of person-time at risk.[18] The aim of this study was to conduct epidemiological analyses of the prevalence and incidence of workplace events reported in a comprehensive "Workplace Conflict" database of a metropolitan hospital system.

Methods

The Occupational Health Services of a large, metropolitan hospital system (n=14,500 employees) administers a unique database of incidents of workplace conflict (WPC). Since 2003, hospital system employees have been encouraged to record all types of workplace conflict, including verbally aggressive behavior, physical and non-physical violence. Incident reports are submitted by employees electronically via the hospital system's computer network on standardized forms. The current analysis encompassed all WPC incidents recorded between 2003 and 2008 in six hospitals. The WPC database was linked with the hospital system's human resource (HR) database, which supplied information on employee age, gender, ethnicity, date of hire, profession and paid productive hours (PPH). All data were de-identified prior to analysis. Overall and one-year incidence rates for workplace conflict were estimated based on the total number of paid productive hours per year. Incidence rates were equal to the number of incidents per 100 full-time equivalents (FTEs). Since paid productive hours were not available by professional group, rates by profession were calculated based on the number of incidents per 100 employees. Incidence rates were calculated by year, hospital, profession, and category of conflict (I-IV).

Results

A total of 1,247 incidents of workplace conflict were recorded over the 6-year period, ranging from 104 to 275 incidents per year. Incidence rates of workplace conflict for each year ranged from a low of 1.84/100 FTEs in 2003 to 4.55/100 FTEs in 2005, with an overall incidence rate of 3.39/100 FTEs (Figure 1).

Overall incidence rates for each hospital ranged from a low of 1.52 to a high of 10.89/100 FTEs. The majority of reported incidents (54%) were worker-to-worker (Type III) violence, followed by violence from patients (Type II), which comprised 41% of all incidents recorded. Type III (worker-on-worker) incidence rates exceeded rates for Type II (patient-to-worker) at all time periods except 2003.

Figure 1. Incidence rates of workplace violence in 6 hospitals by year, 2003-2008
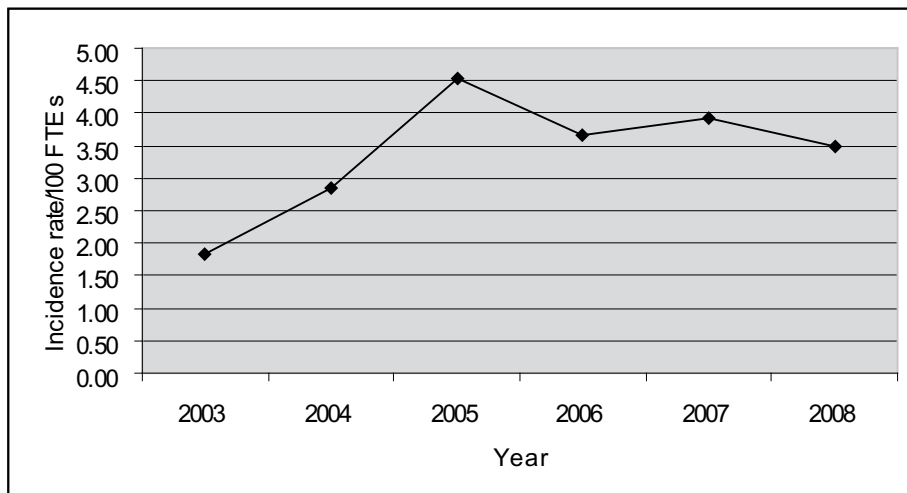
Incidence rates were highest among mental health technicians (133.85/100 employees), surgical technicians (37.58/100 employees) and security personnel (22.83/100 employees). Among the groups with the greatest absolute numbers of reported incidents, nursing staff and patient care associates, incidence rates were lower, 11.62/100 employees and 14.35/100 employees, respectively.

Discussion

Results of this study indicate that workplace conflict is a common occurrence in these hospitals, with an overall incidence rate of 3.39/100 FTEs. Incidence rates increased from a low of 1.84/100 FTEs in 2003, when reporting began, to a high of 4.55 in 2005. After that, rates remained well above 3/100 FTEs annually. It is suspected that these numbers may not reflect a true increase in events but rather may be attributed to employees' growing awareness of, and tendency to utilize, the reporting system. It is difficult to compare these incidence rates with those reported in previous studies, most of which were based on cross-sectional questionnaire studies.[7,19-20] Kling et al[21] also calculated incidence rates of hospital violence based on a database of employee reports, but their study included only reports of Type II violence. In the current study, the highest incidence rate, 10.89/100 FTEs was recorded at a hospital that includes a mental health facility, where aggression from patients is known to be common. This offers some validation of the accuracy of the database. The rate of workplace violence was highest among mental health technicians in this study, and not among nurses, which many other studies have reported.[7-10] In general, conflicts were more commonly reported between co-workers (Type III) than from patients to workers (Type II). This finding contrasts with most previous studies on workplace violence in hospitals that have reported patients as the primary source of violent events.[6,22]

Conclusions

Many hospitals only collect and review data on violent events on an incident-by-incident or case basis. Calculation of incidence rates based on the population at-risk offers a more accurate measure of workplace violence occurrence based on the events reported. Based on epidemiological analysis, the incidence of worker-on-worker (Type III) events was higher than patient-to-worker (Type II) events, and there was substantial variation across hospitals and professional groups. Furthermore, nursing staff were not among those with the highest incidence rates. Both these findings contrast to what is consistently reported on violence towards healthcare personnel in the research literature, which derives from retrospective, cross-sectional designs. These results underscore the importance of conducting epidemiological analysis on an

ongoing basis, so that appropriate prevention efforts can be developed and implemented where they are most needed.

Acknowledgements

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Educational goals
1. Many hospitals only collect and review data on violent events on an incident-by-incident or case basis. Calculation of incidence rates based on the population at-risk offers a more accurate measure of workplace violence occurrence based on the events reported.
2. Based on epidemiological analysis, the incidence of worker-on-worker (Type III) events was higher than patient-to-worker (Type II) events, and there was substantial variation across hospitals and professional groups. Furthermore, nursing staff were not among those with the highest incidence rates. Both these findings contrast to what is consistently reported on violence towards healthcare personnel in the research literature, which derives from retrospective, cross-sectional designs. These results underscore the importance of conducting epidemiological analysis on an ongoing basis, so that appropriate prevention efforts can be developed and implemented where they are most needed.

Correspondence

Mrs Judith Arnetz
Wayne State University School of Medicine
3800 Woodward Ave.
48201
Detroit, Michigan
U.S.
+1-313-577-2015
jarnetz@med.wayne.edu

Nursing and violence in the workplace

Paper

Elizabete Borges, Teresa Rodrigues Ferreira
Oporto Nursing School, Porto, Portugal

Introduction

Health, security and well-being of the workers prove to be of great importance for them, their family, to the companies (productivity, competitiveness and sustainability) and for the world's economy. Accepting that part of human activity unfolds at the workplace it is important to define the healthy workplace is as one *"in which workers and managers collaborate to use a continual improvement process to protect and promote the health, safety and well-being of all workers and the sustainability of the workplace (…)"* (WHO, 2010, p.6).

However, data reveal that 160 million new cases of diseases related with work are occuring (WHO, 2010). The community strategy 2007/2012 to health and security at work *"notes the relation, scientifically proven, between the raise of the stress at work and the diseases resulting, including chronic diseases, cardiovascular diseases and muscle-skeletal diseases"* (2009, p.18) and reminds us that psychological risks at the workplace, such as stress, attacks, destabilization and violence as being threats to health and security at work. In Portugal, the National Occupational Health Program of 2009-2012 mentions *"the relations between work and the worker's health are increasingly recognized and, particularly, the negative effects are now typified and quantified with some rigor"* (DGS, p.6).

According to Di Martino (2008) violence at workplace (bullying) is a global problem. Bullying is defined *"as a situation in which, over a period of time, one or more persons are persistently on the receiving end of negative actions from one or several others in a situation where the one at the receiving end has difficulties defending against these actions"* (Einersen, 2005, p.1). In health care professions, nurses in particular face difficult situations at work associated with violence and insecurity issues (Henderson, 2008; Carrol, 2008, Harding 2008).

Aims of the study

This study aimed to identify the presence, or absence, of psychological violence in the nurse's working place and the relation between psychosocial variables.

Method and materials

This exploratory and descriptive study employed a quantitative research format. This study is one part of other more extent prospective longitudinal study. The sample is made up of nurses / students of the Post-Graduate Course of the OPorto College of Nursing (N=151) who agreed to collaborate in the study.

A questionnaire including psychosocial items and – in order to study the phenomenon of violence (bullying) – the NAQ-R (Einarsen & Hoel, 2001) in the translation and adaptation to Portugese by Araújo, McIntyre & McIntyre, 2004 were employed. The NAQ-R is a self-administered questionnaire consisting on 23 items and evaluates bullying. The participant is asked to tick their perception on negative acts in the workplace referring to the last six months on a frequency scale from 1 to 5 points. Item 23 presents the definition of bullying and the participant is asked, having present the concept mentioned and regarding the same period, tick in a 5 point scale the frequency of the phenomenon. The internal consistency of the instrument (NAQ-R) was analyzed by calculating Cronbach's alpha coefficient which revealed the value of 0.865 in study population.

Results

In the sample of 151 nurses, 84.4 % were female. The average age was 33.1 years old (SD=5.7). Regarding civil status 58.7 % of the nurses were married. Their average tenure is 10.4 years, with 37.1 % of the sample having been working for 5 to 9 years. They work, on average, 44.8 hours per week, 65.6 % were graduated nurses, 73.3 % were permanent staff of the institution. 78.7 % worked at the hospital and 18 %

in Primary Health Care. 24.3 % of the respondents had leadership responsibilities and 33.3 % of the nurses were not satisfied with the working place and had often considered asking for transfer.

From our sample, 9.4 % (14) of the respondents reported having been victims of psychological violence in the past six months. In the past six months the nurses' considered the following as negative experiences: "To be forced to carry out functions below ones level of competencies - 10.6 %", "To be exposed to an excessive amount of work, impossible to carry out - 10 %", "Someone conceals information which affects ones performance - 6.7 %, "Being deprived of responsibility and work tasks" - 4.7%, "Excessive surveillance/control at work" - 3.3%, "To be pushed to not claim work rights (medical certificate, …)" and "Neglect of your opinions or points of view" - 2.6%.

These acts are associated with intimidation, exclusion, work overload/profit and undervaluation of work. The finding that more frequent negative acts corroborate other nursing studies (Stelmaschuk, 2010; Sá & Fleming, 2008; Abe, 2007) and corroborate recent studies with workers from different professions (Tambur & Vadi, 2010).

The comparison of averages, between the subscales of NAQ-R and the psychological variables (civil state, age, professional category, time of service and employment contract) using the Student t and Mann Witney U tests shows statistically significant results. Regarding to the civil status, nurses in "single" situation (single or divorced) have on average (M=12.24) a larger perception of the negative acts associated to social exclusion than married persons (M=11.19) (t (146) = -2.166, p=0.032).

Nurses aged 32-year-old or older perceive being more sensitive to violence related to social exclusion t (145) = - 2.267, p = 0.025, with higher average 12.13 (SD=3.28) than the youger persons (M=11.04; SD=2.33). Regarding the professional category, graduated nurses present a higher perception of the psychological violence related to the social exclusion t (137.160) = - 3.369, p = 0.000 and intimidation t (147) = -2.089, p = 0.038 than the nurses in lower professional categories.

By analyzing the differences between groups and the tenure in the profession we conclude that there are significant differences, notably that nurses with 10 years or more tenure have greater perceptions of negative acts related to the social exclusion t (147) = - 2.366, p = 0.019 (M= 12.13; SD=3.28) than the nurses with less than 10 years of tenure. Also, relative to the service time in the institution the nurses with 8 years or more of service time (M=12.15; SD=3.12) present higher perceptions of social exclusion than the ones with less than 8 years of service time t (135.708) = -2.312, p = 0.022). Regarding the nature of the employment contract nurses with permanent employment contract perceive more social exclusion t (146) = 2.375; p = 0.019 (M=11.97; SD=3.06) and undervaluation of their work t (144) = 1.653; p = 0.049 (M=6.38; SD=2.70) than the ones who have no employment contract.

In terms of satisfaction with the service we found out that nurses who asked or considered asking for a transfer of service experience more psychological violence related to the social exclusion t (84.814) = - 2.048, p = 0,044 (M=11.92; SD=2.72) and undervaluation of work t (124.324) = - 2.940, p = 0,004 (M= 3.42; SD=1.64) than the nurses who seem happier with the workplace.

In summary we can say that being older, being "single" and variables related to a longer tenure in the profession, current workplace, higher professional category and workplace dissatisfaction related represent factors related to the existence of psychological violence at work in the sample under scrutiny.

Conclusion

Psychological violence at work is identified as a multifactorial process. Among others, the International Council of Nurses (2007) participates in the development of "zero tolerance" policies towards this problem. The National Occupational Health Program in Portugal contemplates in their objectives to "improve the quality of work and the life of workers (…) and to protect and promote the workers' health at workplace" (DGS, 2009, p.23). The results of this study sensitize us to the importance of the implementation of intervention models to prevent bullying in Portuguese nurses, with the active role of the organizations in this process.

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Correspondence

Mrs Elizabete Borges
Oporto Nursing School
Rua Dr. António Bernardino de Almeida
4200-072
Porto
Portugal
+35 1225 073 500
elizabete@esenf.pt

Nursing Incivility Scale: Development and validation of a measurement tool

Paper

Ashley Guidroz, Jennifer Burnfield-Geimer, Olga Clark, Heather Schwetschenau, Steve Jex
Denison Consulting, Ann Arbor, USA

Background and purpose

Workplace incivility is defined as a low-intensity behavior with ambiguous intent to harm that violates workplace norms of mutual respect (Andersson & Pearson, 1999). Some estimates of incivility indicate that as many as 9 out of 10 nurses reported experiencing verbal abuse at work (Winstanley & Whittington, 2002). The rise in workplace incivility in hospitals has strong implications for the satisfaction and effectiveness of all healthcare staff, but particularly nurses. The Nursing Incivility Scale (NIS) was designed to assess hospital nurses' experiences with incivility according to specific sources.

In developing an incivility measure for nurses it is important that the scale address the number of sources from whom nurses commonly experience incivility. Previous research has found that uncivil behavior is likely to differ according to the instigator (Jackson, Clare, & Mannix, 2002; Nabb, 2000). Verbal abuse by a physician, for example, may affect nurses differently than verbal abuse by a patient. We were particularly interested in measuring nurse's experience of incivility with physicians, nurse supervisors, other nurses, and patients as distinct experiences.

The review of the incivility research both within and outside of healthcare settings indicates that nurses experience frequent mistreatment from all of the people (i.e., supervisor, patients, physicians, other nurses) that they encounter while on the job. Additionally, this uncivil behavior has been associated with low job satisfaction, psychological distress, increased physical health symptoms, turnover intentions, psychological withdrawal from the field of nursing, and job burnout (e.g., McKenna et al., 2003; Rosenstein, et al., 2002; 2005; Teper, 2000; Winstanley & Whittington, 2002). Given the current nursing shortage (Berlinger & Ginzberg, 2002) and the research linking burnout (Aiken et al., 2001) and patient-to-nurse ratios (Aiken et al., 2002) to patient and nurse outcomes, it is particularly important to understand and address stressors like workplace incivility that could lead to reduced quality of work life, nurse turnover, or other adverse outcomes.

Methods

The NIS was created by tailoring an existing measure of general incivility to a healthcare setting. The first phase involved focus groups to gather information and guidance on tailoring the general measure of incivility for healthcare. This resulted in a survey with 43 items that were divided into five categories: nurse, patient and family, physician, supervisor, and general incivility. After development, a validation study was undertaken using a sample of 173 hospital nurses employed at a hospital in the United States.

Our approach for establishing reliability and validity of the NIS was to use internal consistency and gather evidence of convergent and discriminant validity. Coefficient alpha was estimated for each source to determine if the NIS scales had appropriate reliability. In addition to the NIS, data was also collected about source-specific conflict (Gray-Toft & Anderson, 1981), job satisfaction (Stanton et al, 2002), and nurse stress (Gray-Toft & Anderson, 1981) to establish convergent and discriminant validity. Based on results from the focus groups and our literature review of workplace mistreatment four hypotheses were tested:

H(1) The NIS nurse, supervisor, and physician scales will correlate with NSS nurse, supervisor, and physician interpersonal conflict scales.

H(2) The NIS incivility factors will be correlated with NSS work stress scales (i.e.., Inadequate Preparation, Lack of Support, Workload, Uncertainty with Treatment).

H(3) Physician, Supervisor, and Nurse incivility will be negatively correlated with satisfaction with supervisors and coworkers

H(4) The NIS factors will have no correlation with satisfaction with pay, promotion, or the work itself.

Results

Exploratory factor analysis revealed that the NIS items grouped according to *a priori* scale construction. With the exception of three items, the items of the NIS had communalities above .60 and had no cross-loading with other factors. Scale reliability was assessed by calculating Cronbach's alpha. All values ranged from .81 to .94, which is well above the minimum of .70 recommended by Nunnally and Bernstein (1994).

Mixed support was found for hypothesis 1. As predicted, the NIS Nurse scale had the strongest correlation with the NSS Nurse Conflict scale (r = .53, p < .01). The NIS Supervisor scale had the strongest correlation with the NSS supervisor conflict scale (r = .44, p < .01). And the NIS Physician scale had the strongest correlation with the NSS Physician conflict scale (r = .64, p < .01). The NIS General Incivility scale was moderately correlated with all three sources of conflict. There were also some moderate intercorrelations between other NIS scales and the conflict scales. For example, patient incivility was correlated with both nurse (r = .24, p < .01) and supervisor (r = .27, p < .01) conflict. Additionally, the NIS Supervisor scale was not correlated with any other NSS conflict sources, providing clean evidence of convergent and discriminant validity, but the NIS Nurse and Physician scales were correlated with other NSS conflict sources.

Lack of social support and high workload were significantly correlated with all five sources of NIS incivility (rs .20 or higher, p < .05) providing support for hypothesis 2. Additionally, Uncertainty with Treatment, a stressor that is most associated with relationships with physicians, had the strongest relationship with physician incivility (r = .35, p < .01).

In general, the results for hypothesis 3 were supported. Nurse incivility was negatively correlated with satisfaction with ones coworkers (r = -.23, p < .01). Supervisor incivility was negatively correlated with satisfaction with supervisors (r = -.65, p < .01). There was an unexpected, negative correlation between Physician incivility and satisfaction with coworkers (r = -.19, p < .05).

In support of hypothesis 4, satisfaction with work and satisfaction with promotion opportunities were not significantly correlated with any of the NIS incivility factors; however, satisfaction with pay was significantly, negatively correlated with Physician incivility (r = -.19, p < .05), Supervisor incivility (r = -.28, p < .01), and Patient incivility (r = -.23, p < .01) (See Table 7). In general, we found enough evidence of discriminant validity of the NIS with job-specific satisfaction but the unexpected correlation with satisfaction with pay will be explored in more detail in the discussion section.

Conclusions

The results indicate that the NIS has good psychometric qualities and can be used by hospitals and healthcare administrators to assess the prevalence of incivility. Because the NIS captures the sources from which nurses experience incivility the NIS can provide valuable information to hospitals and researchers looking to design interventions to improve relationships among hospital employees.

Exploratory factor analyses indicate that the items grouped together consistent with our a priori scale construction. The subscales showed good reliability and initial validity estimates indicate that the incivility sub-scales are distinct from each other with only moderate intercorrelations. Additionally, the NIS scales demonstrated good evidence of convergent and discriminant validity as indicated by the predicted pattern of correlation with measures of workplace conflict, nurse stress, and job satisfaction.

There were three unexpected findings that emerged during the course of our examination of the convergent and discriminant validity of the NIS. First, the NIS factors showed some unexpected correlation with source-specific conflict items, as measured by the NSS. Specifically, the Nurse and Physician incivility factors were weakly but significantly correlated with all three sources of conflict. Also, Patient incivility was correlated with conflict with physicians and conflict with nurses. We do not find this result to be as troubling given two pieces of information. First, the Supervisor incivility factor was the cleanest of the factors and did not correlate with the other sources of conflict. Also, the magnitude of the unexpected correlations between the Nurse and Physician factors was much smaller than the magnitude of the correlations between the hypothesized relationships. That is, although Nurse incivility was correlated with supervisor and physician conflict, the strength of those correlations were much weaker than the strength of the correlation with Nurse conflict. All of the unexpected correlations were small in magnitude which suggests that the NIS is measuring construct space that is not captured by items that assess the amount of conflict nurses experience with other coworkers.

A second unexpected finding was a small, negative correlation between Physician incivility and satisfaction with coworkers. We had hypothesized that only Nurse incivility would be negatively correlated with coworker satisfaction. Again, this correlation was small in magnitude so interpretation is limited, but this does suggest that nurses may include physicians within their psychological grouping of coworkers, as opposed to perceiving physicians as supervisors.

Lastly, the significant, negative correlations of pay satisfaction with Physician, Supervisor, and Patient incivility were surprising. We had hypothesized that this facet of job satisfaction would not be correlated with any source of incivility. Although small in magnitude, the correlations suggest that as nurses experience more incivility from these sources in their work environment, they also feel less satisfied with their salary. Dissatisfaction with pay is not unusual but this finding does suggest a potential outcome to incivility that is worth exploring in future research. Nurses who experience high levels of incivility may be more inclined to feel that their compensation is not adequate for the amount of socially-based stress they encounter. This may potentially exacerbate the nursing shortage problem as dissatisfied nurses seek less stressful jobs.

The NIS captures the sources from which nurses experience incivility and can provide valuable information to hospitals and researchers looking to design interventions to improve relationships among hospital employees. One potential application of this scale is to use it as a baseline assessment of incivility (similar to a "stress audit" for example) to gauge the sources and types of incivility that are most problematic. A targeted intervention can be implemented to address those concerns, followed by subsequent measurement to determine the extent to which incidents of incivility have declined and other outcomes have improved (e.g., employee well-being). Additionally, this measure can also be used in the future to accumulate data on the prevalence of incivility in healthcare on a more global scale. This information, to date, has yet to be published but has tremendous potential for improving the assessment of workplace incivility.

Acknowledgements

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Educational goals

1. To provide evidence of validity of the NIS and educate audience members on a potential measure that could be useful for hospitals
2. To provide example of how to develop a good quality measure for assessing negative workplace behavior.

Correspondence

Mrs Ashley Guidroz
Denison Consulting
121 West Washington Street
48104
Ann Arbor
USA
+1 734-302-4002
amguidroz@gmail.com

Aggression against staff of ambulance services

Paper

Alexander Auer
Vienna Ambulance Service, Vienna, Austria

Background

Aggression and violence on various jobs have been receiving more and more attention in the last years. Particularly in psychiatry and in school spheres constantly new studies are being published. Violence is a high risk-factor in the ambulance emergency services which is difficult to control due to the varied workplace settings (for example on the street or at the patient's home).
The first part of the study addresses the question, of how emergency services deal with aggressive encroachments against their staff. In the second part the monitoring system for aggressive encroachments of the "Vienna ambulance service" will be evaluated.

Method

By means of a questionnaire 35 emergency services and rescue schools were asked about their procedures in case of aggressive encroachments. The monitoring system of the "Vienna Ambulance Service" is based on the SOAS-R questionnaire and was statistically evaluated.

Results

Twenty one of a total of 35 administered questionnaires were returned. In December 2007 203 attacks on the staff of the Vienna Ambulance Service were reported. Given the number of 268.528 treatment episodes patients this gives rise to a incidence of
 Thus, on average, an attack happened on every third day. One hundred and eighty eight (
Most attacks were perpetrated by male patients family members 15%) and bystanders (5%).

In line with the findings of About a quarter of the perpetrators is aged between 30 and 40 (26.6%, n = 54). Just over one third of the patients were The proportion of aggressive people under the influence of drugs is at 6.3% at the lower end of the range of diagnoses.

Concordant with the findings of Steck-Egli (2005, p. 37) and Reinhardt (2007, p. 4) the majority of attacks occur at weekends. Unlike Reinhardt (2007) the lowest number of attacks occurred on Wednesdays not on Mondays. Around one third of the incidents occurred in the ambulance
In 36% of all incidents the trigger for the aggression was an understandable reason and 31.5 % of all incidents occurred during caring for the patient. In comparison to existing studies the perpetrators in the present sample made significantly more use of ordinary objects and body parts during violent behavior, than reported in studies conducted in in-patient settings (see Table 1).

Table 1: Comparison of the proportion of means of aggression with other studies

	The means or methods of aggression		
	Ordinary objects	Part of the body	Dangerous objects and/or methods
Vienna Ambulance Service	14,8%	89.2%	6.9%
Ketelsen (2005)	4.5%	21.5%	4.5%
Steck-Egli (2005)	10.2%	39.8%	1.1%

In 90.6% of cases, paramedics were the target of attacks followed by drivers (25.6%) and emergency physicians (15.3%). Objects, family-members, patients, bystanders and policemen were also reported as the target or as the victims of violence. The large proportion of injuries following attacks on persons of 45.8% in the present study is much higher than in proportions found in institutional settings of 17.2% (Steck-Egli 2005), In 41 (20.2%) cases attacked people underwent treatment by paramedics or doctors. In 68.5% of cases the victims felt threatened, 26 apparatuses were damaged and half of them had to be

replaced. In 67.5% of the cases a conversation with the aggressor was sufficient to calm the aggressor down and 46.8% of cases the police were consulted.

Conclusion

Aggression against emergency service staff is a topic for discussion in many organizations. Standardized signaling systems in different states of development are not common. The "aggression collection sheet" of the "Vienna ambulance service" has been shown to be practicable for recording aggressive events as well as for monitoring the progress control and/or evaluation of de-escalation-skills. The present investigation shows that aggression is a problem which must be taken seriously in the emergency services and appropriate precautions must be institutionalized. This is the first official study of violence against staff of ambulance services. The study shows that the SOAS-R can be adapted for out-patient services in the health sector.

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Correspondence

Mr Alexander Auer
Vienna Ambulance Service
Radetzkystrasse 1
1030
Vienna
Austria
+43 1 4000 70151
alexander.auer@auer-aggressives.at

Workplace bullying: Alternative approaches concerning causes and impact

Paper

Jan Gregersen
Akershus University College, Lillestrom, Norway

Workplace bullying is a widespread kind of violence in the health sector. E.g. a recent study (HOUPE study 2010) shows alarming figures concerning physicians affected by harassment/bullying in University Hospitals, (one of three in Norway, one of two in Italy). The Journal of the Norwegian Medical Association frequently presents long-lasting discussions concerning alleged bullying cases in the health sector, usually involving counterparts who deny that it ever happened. Although workplace bullying is banned in several countries, there is still considerable discussion in newspapers, seminars and elsewhere concerning how to understand the phenomenon and the concepts being used to explain it.

Einarsen, Glasø & Nielsen (2008) presented a current literature review of the field of "workplace bullying". The authors provided here "an overview of important research results on its nature, causes and consequences" (p. 308). They argued, however, that we still know too little about how bullying can best be prevented and managed. The authors, therefore, called for intervention studies in organisations.

Einarsen & al (2008) further described Workplace Bullying as either dispute related, (arising put of an initial or ongoing *conflict*), "*predatory*" or a combination of the two. From this modelling bullying is a process that escalates in severity over time and often results in victims' long-term *Post Traumatic Stress Disorder*. Other researchers have, however, seen reason to question both these assumptions. Such conceptual problems are likely to be more apparent, when focus of research is moving on from statistical and descriptive purposes to intervention studies and advice for practitioners, i.e. the way from awareness to sustainable action. The present article is a discussion paper which aims to explain what these objections are about and how they can affect our understanding of the phenomenon on the basis of this article (Einarsen & al 2008).

Is workplace bullying a conflict?

In Norway there have been tense discussions in the press and elsewhere whether bullying should be labelled a type of conflict. Below three research contributions will be used to illustrate what these different views concerning the relationship between bullying and conflicts are about.

1. A pioneer in the field of "bullying in the workplace" was Heinz Leymann (1932-1999). He was German-born, but later had his work in Sweden. His articles are still frequently referred to throughout the world. Leymann (1996) thought that bullying was caused by escalated conflicts that management was not able to handle. He was therefore particularly concerned about early intervention when conflicts aroused and the use of external assistance when these were out of control. This may fit with an early "traditionalist" view that claimed that conflicts were disruptive and had to be avoided (Robbins 2005).

2. But Ege (2002) countered Leymann. His objections can be illustrated by what he calls "a banal example" (p. 20, here abbreviated):
   A car stops and the question is why. An obvious explanation is that it once started. On the other hand, there is no logical connection that binds these two events along. Only if we look for events that are closer to the fact that the car stopped (for example, that it missed the move) would such an explanation of a process make sense and the room to ask relevant questions.

Like a car running, Ege (2002) saw conflict in a broad sense as a natural and unavoidable side of working life. Therefore he considered it as a *zero condition* for a bullying process, but not as an explanation of why it happens. Rather one should watch out for conflicts with special characteristics. Ege labelled these "targeted conflicts" or "stalking", which are the useful precursors to bullying. This notion seems close what Robbins (2005) called a "Human Relations" view of the conflicts that perceive them as normal phenomena in all groups and organisations, and therefore inevitable.

3. Westhues (2004) argues that well-functioning organisations are characterised by being based on reciprocity and dialogue, which also requires room for bickering, debating and friction, i.e. conflicts. Bullying implies, however, an almost total breakdown of such a dialogue. All power is in larger and larger extent transferred to the bully's side, while the target is increasingly powerless. It is therefore not the conflicts that contribute to bullying, but rather attempts to suppress them through delaying tactics, abuse of power and retaliation. Westhues' view may suit what Robbins (2005) labelled an "interactionist" understanding of conflicts. This direction assumed that harmonious and peaceful organisations would not be able to meet the challenges of the environment with the necessary change and innovation. Conflict was therefore considered a prerequisite for their survival.

Decision maker's perception of the relationship between conflict and bullying, can have a direct impact on decisions taken. For example, in court a judge regarded a bullying case as a conflict between the applicant and her superior in the workplace, where the two constantly confronted each other. This reasoning was in line with the "traditionalist" view as mentioned above. However, in this way the court ignored the possibility that the alleged "bully" could have targeted the other one and thereby forced the victim to a certain type of behaviour. If so, the term "conflict" would be misleading as argued by Westhues (2004). In this lawsuit the one who claimed to have been bullied lost the compensation claim. If the judge had chosen a different modelling on this point, the outcome would probably have been another (Bondi & Gregersen 2004).

Predatory bullying

Einarsen et al. (2008) supported the view that bullying could be conflict-related (combat bullying) (in line with Leymann's view above), but stated that that there was also another kind, labelled "predatory bullying". The latter was characterised in the way that the victim happen to be in a situation where someone carries out power abuse, or where someone is using aggression for their own personal gain. This version may look similar to Westhues' understanding of bullying above.

The distinction between combat bullying and predatory bullying seems analogous to the concepts being used in another survey, this time among school children (Roland & Idsøe, 2001). Here, the authors concluded that "proactive" aggression (the tendency to attack someone in order to achieve material or social benefits) was the dominant form of bullying, whereas "reactive" aggression (the tendency to express negative behaviours when one was angry) seemed far rarer. However, it is worth noting that while Einarsen & als (2008) description of predatory bullying emphasised the victims' innocence, Roland & Idsøe (2001) were concerned about the perpetrators' motives. Yet both of these approaches offer a fundamentally new dimension to the understanding of the link between conflicts and bullying compared to one by Leymann (1996), presented above. As mentioned, he implicitly assumed that all bullying were rooted in conflicts.

Personality

In the same overview article mentioned above (Einarsen et al., 2008), various personality profiles among groups of bullying victims and bullies that increase the likelihood that they ended up in such roles were mentioned. The personality aspect was, however, not presented here as a cause of bullying, but rather as possible statistical correlations. Still it gives reason to question the assumptions of Leymann, Ege and Westhues that harassment must be understood from the situation and not the participants' personality. There is considerable literature about notorious troublemakers (e.g. Hare 1991), which points out that there are people who are constantly likely to get involved in destructive actions against others, if only they are given an opportunity to do so. In such cases, it seems reasonable to discuss whether it might better to regard such "ticking bombs" as a cause. A model, which takes for granted that all bullying is rooted in particular situations, will probably assume that such destructive personalities do not exist, or somehow define such cases as another problem.

Long-term impact

Previously the term Post-Traumatic Stress Disorder (PTSD) has been frequently used to describe the long-term impact on victims of workplace bullying (Einarsen & al 2008). However, Linden (2003) argued that this label could in some cases be misleading, and rather be diagnosed as Post Traumatic Embitterment Disorder (PTED). Although the symptoms were overlapping on some points, there were also considerably differences and another approach is needed. Whereas PTSD is caused by a life-threatening or extraordinary physical event, PTED is the result of more ordinary happenings in life (although they may be extreme) such as divorce, dismissal, cultural shock or likewise. Unlike the PTSD sufferers, the PTED types direct the frustration against the surroundings in terms of bitterness and they rarely feel need for personal

treatment. Ege (2010) argued that PTED seems better suited for victims of workplace bullying. Thus also the long-term impact on victims has recently been questioned.

Conclusion

"Workplace bullying" is a negatively loaded term that also lacks a generally accepted operational definition. This is an unfortunate starting point for a field of science. But as long as the research is limited to case studies and generalisations of descriptive nature, the conceptual level of precision is probably less important than the knowledge that is aimed at prevention of or dealing with the problem in practice. Einarsen et al (2008) advocates steps in that regard. This article points out some of the challenges involved.

The early phase of workplace bullying research was based on the assumption that bullying were caused by forgoing conflicts. Later other researchers disagreed and even thought that absence of conflicts were more likely to cause bullying. Such a seemingly wide gap of perceptions can easily raise confusion and uncertainty among practitioners, and also give room for choosing modelling according to convenience. E.g. an employer, who regards bullying as a conflict between "parties", can remain in his/her position as a "neutral third party". However, whenever a person in charge regards the events as a one-sided offence, he/she would him/herself easily get into the position of a counterparty against the bully.

Thus there is no wonder that this question has already led to intense discussions. Both bullying and conflicts have blurred boundaries. Therefore, understanding what these words are supposed to mean will largely be up to those who may have authority to make decisions in each particular case, within or outside the actual workplace. This involves a high degree of unpredictability for those concerned. If advice aimed for practitioners is based on a conceptual relationship between conflicts and bullying, it is a need for further clarification what these concepts actually mean, and how they are related.

According to Einarsen et al (2008) there is also another type of bullying labelled "predatory", which requires that the victim came undeserved into the bullying process. However, it may prove difficult to prove someone's innocence, and this approach could easily lead to an over-focus on the victimised target. An overlapping concept of predatory bullying is "proactive aggression". However, this concept rather emphasises the bully's profit motive, which is probably not easy to measure in an objective manner, either. Nevertheless, if the "proactive" behaviour is the dominant reason for bullying among adults (as it is claimed to be for children), it is possible that this approach will gradually open to a new insight and in turn link workplace bullying to studies of notorious bullies. This aspect was ignored in the early stage of workplace bullying research, and may still be underestimated.

Einarsen & al (2008) describes the possible long-term impact on victims as a kind of personal suffering of those affected. However recent studies rather view this long-term effect as embitterment directed at the surroundings. If so, this distinction is not only suited for therapeutic purposes. There is also reason to further emphasise the long-term risks and costs which result from such attitudes in terms of destructive behaviour or even physical violence. This kind of knowledge could be a suited incitement for employers and other authorities to actually solve workplace cases in a fair way and avoid that they choose models of convenience as discussed above.

When research in this field aims to be transferable from experts to practitioners, it can have direct consequences for the affected and in addition will have to take into account more than one party. This will require very different demands on precision and conceptual modelling than hitherto research as presented in the commented article (Einarsen & al 2008). Thus the present author will agree with their conclusion that for these new purposes there are considerable needs for more research, but add that it also seems to be a clear need to continually critically reconsider the suitability of the material already provided.

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Educational goals
1. The presentation is primarily of interest for researchers, helpers and authorities concerned with workplace bullying in the health sector.

Correspondence

Mr Jan Gregersen
Akershus University College
P.O.Box 423
2001
Lillestrom
Norway
+47 648 49 000
Jan.Gregersen@hiak.no

Social capital indicators in predicting, and assessing, violence and aggression in adolescent communities

Paper

Paul Linsley, Roslyn Kane
The University of Lincoln, Lincoln, UK

The importance of situational factors in the aetiology of violent incidents is the most strongly emphasized in social interactionist views of aggression and violence (Duxbury et al. 2008; Paterson, Leadbetter and McKenna 2008). Violence and aggression are herein seen as a possible outcome of negative interpersonal interactions, which are, in turn, embedded in the broader social and organizational context in which they occur. Particular attention is therefore paid to any factor that might influence the nature of the exchange between the interacting parties. Such factors extend from characteristics of the individuals involved, through the nature and motive for their interaction; to the environmental and socio-cultural context in which the interaction takes place.

Importantly, this kind of social interactionist analysis is better able to explain the underlying character of the majority of violent and aggressive (Paterson, Miller & Leadbetter 2005). The point here is that not all forms of violence are identical in their social and psychological underpinnings. Rather, a number of types of work related violence can be distinguished. In turn, intervention aimed to prevent or reduce violence must be informed by valid and appropriate understanding of its causes. What works to reduce or prevent one type of violence may have no beneficial bearing upon another type. Moreover, each common type of violent incident must be analyzed for its consistent factors.

Precisely because violence occurs across a multitude of occupational settings, the inference is drawn that at least some of its antecedents must be found in a set of common characteristics amongst perpetrators, such as prior record of violent behaviours, a history of drug or alcohol abuse, a mental disorder, poor coping skills and social resources, etc. Notwithstanding the likelihood that each, or a combination, of these factors makes a person more likely to engage in violent behaviour, the fact remains that the individual propensity for violence, however strong it is, still needs to be triggered. This fact immediately brings a range of situational factors to the fore.

Social capital is an expansive concept, one that includes facets such as sociability, social networks, trust, reciprocity, and community and civic engagement. Coleman (1988) and Bourdieu (1980, 1986) are normally credited with the introduction and promotion of the defined concept of social capital. Bourdieu (1980) defines social capital in terms of social networks and connections. He posits that an individual's contacts within networks result in an accumulation of exchanges, obligations and shared identities that in turn provide potential support and access to resources. Coleman emphasizes the idea that social capital is a resource of social relations between families and communities.

It is suggested here that youth, because of their limited mobility, may be particularly affected by the growing social and spatial isolation within living communities and that this in turn has an impact on violence and aggression and adolescence drug and alcohol abuse as teens struggle to make sense of the world around them.

This presentation will look at social capital indicators used within an original piece of research to assess for adolescence violence and aggression and substance and alcohol misuse. It will also draw on other research of this kind to demonstrate how these social capital indicators were developed and deployed.

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Educational goals
1. For participants to gain a greater understanding as to the concepts behind social capital measurements
2. For participants to develop an understanding of how these may be applied in the research of violence and aggression

Correspondence

Mr Paul Linsley
The University of Lincoln
Brayford Pool Campus
LN6 7TS
Lincoln
England
+44 1522 882000
plinsley@lincoln.ac.uk

Chapter 6 - Patterns of staff and institutional aggression and violence against clients

South African professional experiences of caring for HIV/AIDS patients

Paper

Nthomeni Dorah Ndou, Leinnet De Villiers
University of South Africa Mears, Tswane / Pretoria, South Africa

Key terms: Acquired Immunodeficiency Syndrome (AIDS); Ethics; Existential frustration; Existential vacuum; Experiences; Human Immunodeficiency Virus (HIV); meaning of life; risk; Therapeutic relationship; Victor Frankl.

South African Professional nurses are exposed to the risk of Human Immunodeficiency Virus (HIV) infection and contracting the Acquired immunodeficiency Syndrome (AIDS).

Qualitative phenomenological research was conducted to explore registered nurses experiences of working in such a high risk environment and how their experiences influence the therapeutic relationship. A sample of registered nurses who care for HIV-infected persons who suffer from AIDS was purposefully selected. Focus group interviews were conducted. Qualitative data analysis was performed. Frankl`s theory of meaning of life served as theoretical foundation for interpreting the research findings. The research results revealed that professional nurses experience existential frustration due to the intentional (patients smear blood on nurses whilst inserting intravenous infusion) and unintentional risks that they are exposed to. This negatively impacts upon their ability to maintain a healthy therapeutic relationship with patients. However evidence was obtained indicating that some factors support their quest for finding meaning in life in the workplace.

Educational goals
1. To make nurses aware of the abuse experienced whilst caring for HIV/aids patients
2. To discuss the support that should be given to nurses experiencing support.

Correspondence

Mr Nthomeni Dorah Ndou
Department: Health Studies
University of South Africa Mears
0003 Tswane / Pretoria
South Africa
+27 720100571
ndound@unisa.ac.za

Clique behaviors in nursing: A new trend

Paper

Nashat Zuraikat
Department of Nursing and Allied Health Professions, Indiana University of Pennsylvania, Indiana, USA

Abstract

When you hear the word clique, childhood memories automatically come to mind. Clique is defined as a group of people who share interest, point of views, purposes or certain behaviors. Factors that contribute to the formation of cliques are social standing, similar goals, and friendship. Literature has showed that cliques have been associated with job dissatisfaction, absenteeism, sick leave, psychological stress, and turnover. It is the nursing manager's responsibility to investigate and deal with clique behavior by indentifying this behavior by providing a supportive, no blaming, learning environment as well as offering an educational workshop about bullying, its consequences and impact on staff and patient care. Furthermore, managers must guard against forming adult cliques and watch out for those forming around by developing and promoting a cohesive team where nurses feel they are included and valued.

Correspondence

Mr Nashat Zuraikat, PhD, RN
Professor of Nursing
Department of Nursing and Allied Health Professions
Indiana University of Pennsylvania
Indiana PA
USA
zuraikat@iup.edu

Identification of abuse in elderly persons: prevalence, risk factors and tools for identification

Workshop

Miri Cohen
Faculty of Social Welfare and Health Sciences, University of Haifa, Haifa, Israel

Introduction

The World Health Organization has defined elder abuse as a single or repeated act, or lack of appropriate action, occurring in any relationship where there is an expectation of trust, which causes harm or distress to an older person (Krug, Dahlberg, Mercy, Zwi & Lozano, 2002). It includes physical, psychological and sexual abuse, financial exploitation, passive or active neglect, and violation of rights (Payne & Burke-Fletcher, 2005). A broad definition of abuse in long-term care also includes violation of care, such as lack of privacy, de-individuation, infantilization and disrespectful behaviors, which impair quality of life of the elder persons (Lowenstein, 1999).

Community-dwelling elderly are abused mainly by family members, while in nursing homes is often by the staff, although abuse by family members is possible. The prevalence of elder abuse in the community, as found in population-based surveys in the USA and Western countries, has been determined at between 5% and 20% (Isikovitc, Lachs & Pillemer, 2004). Yet there is broad consensus that this rate is significantly lower than the actual one, as it is based on elderly people identified with signs of abuse or on reports by older people willing to admit to being abused; many cases go unreported (Lachs & Pillemer, 2004; Voelker, 2002). Precise data on the prevalence of abuse or neglect in long-term institutions for the elderly are lacking, because of the hidden nature of abuse in institutions and inadequate means for its assessment and identification in them (Liang, 2006). Studies in Europe and USA reported rates of 11% to 79% of staff witnessing or executing acts of abuse (Goergen, 2001; Pillemer & Moore, 1989; Saveman, Astrom, Bucht, & Norberg, 1999).

Elderly residents of long-term care institutions are particularly prone to abuse and neglect, due to their often physical and mental frailty and dependency, social isolation which limits ability to report, and fear of being punished or subjected to vengeance by the carers who are guilty of the abusive behavior (Joshi & Flaherty, 2005). Occurrence of abusive behaviors by nursing home staff has been found related to the highly stressful nature of the work, which is often due to insufficient staffing, time pressures and aggressive behaviors of the residents (Goodridge, Johnston, & Thomson, 1996), as well as personal stressors that reflect into the work setting, combined with insufficient training and lack of supervision and administrative support (Hawes, 2003).

Identification of abuse is highly complicated due to its complex and often uncertain nature. Existing means are prone to misidentification of elder abuse: cases may be missed due to efforts to hide the problem, unawareness and low training of professionals; false identification may occur because of confounding medical conditions or spurious complaints by elder persons suffering from cognitive or mental difficulties, or by family members with unrealistic expectations. In several studies doctors and nurses were asked about detecting elderly people who suffer abuse; many of them were oblivious to the subject, and could not identify such elderly patients in their care (Britt-Inger & Asa, 2001).

Most cases of identification of abuse are by identification of its actual signs; professionals generally lack the skills for identifying elderly people who do not complain of abuse or identify themselves (Mion et al., 2001).

Objectives

The first aim is to show the prevalence of different types of abuse and neglect in community swelling and in residents of long-term care facilities and their associations with risk factors, demographic and health variables, and staff's attitudes. The second aim is to present a three-dimensional tool to identify elderly persons suffering or at risk for abuse.

Methods

The data here are based on five studies conducted between 2000 and 2009, in two main hospitals, in long-term facilities, and in the community. Elderly patients and their main family caregiver were interviewed. The studies used a semi-structured tool to identify risk for abuse, a list of signs of abuse and a questionnaire for disclosure of abuse. Results of blood tests were also obtained.

Results

1. Types, prevalence and indicators of abuse

Two consecutive studies were conducted in internal medicine and orthopedic surgery departments in two major hospitals in Israel, with 108 participants (Cohen et al., 2006) and 730 participants (Cohen et al., 2007; Cohen 2008), respectively. The first study (Cohen et al., 2006) was mainly meant to assess of the new tools constructed, while the second focused on describing prevalence of types of abuse by various means of identification (Cohen et al., 2007). Eligible patients were aged 70 years and older, were community-dwelling persons, and needed some help from their family members before hospitalization. Forty-three (5.9%) respondents disclosed experiencing abusive behaviors by family members during the previous year. Ten of them reported one type of abusive behavior, four to nine reported two to six abusive behaviors, and four respondents each reported seven to ten. Most of the complaints were about a general sense of being threatened by a family caregiver and about psychological abuse. For 156 (21.4%) patients evident signs of one or more types of abuse were identified. For 83.3% of them (N=95) one type of abuse was identified, for 35 (22.4%) two types, for 22 (14.1%) three types, for two patients (0.2%) four types, and for two more patients five types of abuse were identified. Physical and sexual abuse was rare, while neglect, psychological abuse, and financial exploitation ranged from 8.9% to 14.4% of the sample (Cohen et al., 2007; Cohen, 2008).

In a third study (Cohen et al., 2010), conducted with elder persons hospitalized in internal medicine departments, 31.0% (N=22) patients reported experiencing to some extent maltreatment or abusive behaviors, mostly instances of disrespectful behavior. Signs of abuse, mostly neglect and mostly mild, were detected in 22.5% (N=16) patients.

Main predictors of actual abuse for community dwelling persons were higher objective and subjective caregiving burden, respondents' higher functional disability, more emotional difficulties of the elder persons, more family problems of the elderly and their caregivers, financial dependence of the caregiver, and lower albumin in blood (indicator of worse nutritional status) (Cohen et al., 2006; 2007; Cohen 2008). Predictors of abuse in long-term facilities were higher ADL dependency, lower albumin level, and more emotional and behavioral problems of the elder persons (Cohen et al., 2010).

In another study (Shinan-Altman & Cohen. 2009) 208 nursing aides from 18 nursing homes completed demographic, work stressors, burnout and perceived control questionnaires, and a case vignette questionnaire, to test attitudes condoning elder abuse. Attitudes of condoning abusive behaviors were predicted by higher levels of work stressors (role ambiguity and role conflict), burnout and low income.

2. A three-dimensional model for screening for abuse in older persons

Due to the complexity and elusive nature of elder abuse we developed a three-dimensional tool to identify it (Cohen et al., 2007). It was used in subsequent studies (Cohen, 2009; Cohen et al., 2010). The tool is necessary for successful identification of elder persons suffering abuse, as the studies showed that none of the single tools can identify all cases and that only partial overlap exist between the tools. These tools, which will be presented and explained in the workshop, consist of three parts (Cohen et al., 2007):

a) A direct 10-item questionnaire probing whether and how often the person suffered from abusive behaviors (e.g., physical violence, verbal violence, being coerced, or forbidden, to do activities, being forced to hand over property, being forced to give financial support against his/her will, etc.). Although professionals often refrain from asking direct questions about abuse due to uneasiness or fear of causing embarrassment, we found that when this was done in a secure and emphathetic setting many of the sufferers of abuse inclined to disclose it.

b) Looking for evident signs of abuse, using a list of possible signs of physical, psychological, and sexual abuse, financial exploitation, and neglect. Using this list, professionals during their interaction with the patient can observe him/her, ask relevant questions, or observe his relations with his carers. Examples are looking for suspicious wounds, bruises or burns, especially unusual ones; for signs of neglect such as dress inappropriate dress for the weather; low hygiene, skin sores, etc.

c) An indicators-of-abuse tool is needed to identify risk factors. Although risk factors are not equivalent to the existence of abuse, their existence was confirmed in many instances of abuse. The tool we developed, the Expanded Indicators-of-Abuse (E-IOA), was based on the indicators of abuse described by Reis and Nahmiash (1998). It was found to have good validity and reliability. It contains 11 indicators of risk in respect of the elder person and the caregiver (e.g., behavior problems, emotional difficulties, family/marital conflicts, poor interpersonal relationships, drug or alcohol abuse). Likewise blood tests, such as low albumin level (absent medical diseases that can create low albumin levels in blood), when possible to obtain, are an important indicator. In a recent study with 1317 participants (not published yet), we show that a shortened version, with four risk indicators, succeeded in identifying 94% of elder persons suffering abuse and clearly distinguishing abused from non-abused participants.

Conclusions

Elder abuse is a major problem in community-dwelling elderly persons and in residents of long-term care facilities. Its identification should be a major goal of the health and welfare professions. Thorough assessment by the three-dimensional approach, direct questioning, detection of signs of abuse and identification of risk factors for abuse is an efficient tool to identify and prevent abuse in long-term care facilities. Also, training and supervision programs should be developed to modify attitudes and reduce work stressors and burnout, which constitute risk factors for abuse, among nursing home's staff.

Acknowledgements

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Correspondence

Miri Cohen
Gerontology Department
Faculty of Social Welfare and Health Sciences, University of Haifa
Mount Carmel
31905 Haifa
Israel
Cohenm@research.haifa.ac.il

Chapter 7 - Patterns of client aggression and violence against staff

From Attention-Deficit/Hyperactivity Disorder and related disorders to (re)victimization among penitentiary workers

Poster

Fanny Klerx-van Mierlo, Stefan Bogaerts
INTERVICT, Tilburg University, Tilburg, The Netherlands

Abstract

Background

Workplace aggression has become a well-known problem. Current research focuses mainly on perpetrators' typologies and the approach of the perpetrators. Workplace related victim research on the causes of workplace violence from a victim perspective is under-represented.

Objectives

This research in Dutch prisons examines individual factors in relation to workplace aggression. We assume that some individuals become more likely a victim of aggression at work. Predictors include personality and behavioral variables such as Attention-Deficit/(Hyperactivity) Disorder (AD(H)D), childhood maltreatment and Post-Traumatic Stress Disorder in adulthood (PTSD). We suppose that physically victimized penitentiary workers suffer more from AD(H)D, childhood maltreatment, and PTSD than non-victimized workers and have more inadequate coping strategies to deal with problems and to reduce (re)victimization.

Study aim

The first purpose of the study is to determine the prevalence of these factors in a large group of penitentiary workers who were (not) victimized in the previous 12 months. The second purpose is to correlate between physical violence of detainees against penitentiary workers and the risk-factors mentioned above. The third aim is testing a conceptual model for causality, through conducting a longitudinal study.

Design of the study

The longitudinal study consists of three waves on which a set of validated instruments on the above mentioned concepts will be filled out by approximately 500 penitentiary workers (consisting of victims and non-victims of physical violence by detainees in the past 12 months). Besides quantitative measurements, 25 in-depth interviews are held to investigate personal, sensitive, or confidential information. The data-collection will be preceded by a pilot-study on 80-100 penitentiary workers, starting March 2010.

Educational goals
This study builds on previous studies on violence and aggression in penitentiary institutions, and will specifically aim to explore victimization of penitentiary workers by detainees.
1. The results of the study will contribute to the knowledge of who is more likely to become a victim and who is not.
2. This study may provide insights into the prevention of workplace related aggression and may provide possible indications in the context of the selection of prison staff.

Correspondence

Mrs Fanny Klerx-van Mierlo
INTERVICT, Tilburg University
Warandelaan 2
Postbus 90153
Tilburg, Netherlands
+31 13 466 89 13. f.klerx@uvt.nl

Identification of aggressive and violent acts with the SOAS-R: Incidence, nature and risk factors on three psychiatric services

Paper

Didier Camus, Nicolas Kuhne, Jean-Philippe Duflon, Jean-Michel Kaision, Mohammad Mehdi Gholam Rezaee
DP-CHUV Lausanne Hôpital de Cery, Prilly/Lausanne, Switzerland

Abstract

The quality and safety of care are key themes for the public, health professionals and policy makers. In psychiatric settings, aggressive and violent incidents are well recognized as important phenomena threatening the above goals mentioned.

In the Lausanne University Psychiatric Department, the registration of aggressive and violent incidents with the SOAS-R began in the psychiatric hospital for adults since 18 months and be developed then in psychiatric hospitals for elderly and for children/adolescents. Before this, little was known about the frequency and the circumstances under which incident incidents they occur.

This presentation aims to describe the implementation process put in place in theses hospitals, to report results of the recording (nature of the incidents, patient characteristics, victims' description, and differences between hospitals) and to examine the use of the scale in clinical settings.

The presentation also aims to show the importance of some appropriate care programs and to describe work done as well as the work that remains to be done to tackle the problem of violence in psychiatry as a whole.

Educational goals
1. To describe the violent patients population and risk factors related to violence in psychiatric hospitals
2. To emphasize the importance of specific programmes to limit the risk of violence in clinical settings

Correspondence

Mr Didier Camus
DP-CHUV Lausanne Hôpital de Cery
Route de Cery
1008
Prilly/Lausanne
Switzerland
+41 21 643 63 47
Didier.Camus@chuv.ch

Violence among adolescent psychiatric inpatients in a Norwegian closed ward

Paper

Inge-Arne Teigset, Per Olav Naess
Oslo University Hospital, Ullevaal, Oslo, Norway

Abstract

Objective

The present study investigates the frequency and seriousness of incidents of violent behaviour among 89 (41 girls and 48 boys) adolescents aged 12 to 18, hospitalised in a closed psychiatric ward during a ten-year period from 1988 to 1998. Co variation between violence in the ward and psychiatric diagnosis, situational variables, gender, violence prior to hospitalization, and having been violently or sexually abused, is examined.

Method

Retrospective information about all incidents of violence in a closed adolescent psychiatric ward during a ten-year period was collected and systematized. Circumstances surrounding the violent episodes were registered and the violence categorized as reactive or non-reactive and as serious or less serious violent episodes. Information about family relations, including possible physical or sexual abuse, and diagnosis according to ICD-10 was also gathered.

Results

27 (30 %) of the 89 patients had committed a total of 164 violent episodes. One in four episodes (44) was of a serious nature. A small minority committed most of the violence; five patients were involved in 58 % of the episodes. Typically, those who committed much violence had themselves been physically and/or sexually abused. A small minority committed serious violence; 68 % of all serious violence was committed by three patients. The occurrence of a second or third violent episode appears to be a strong warning sign for frequent and serious violence in the future. 62 % of the violence was reactive, immediately following intervention from staff. In other instances, where no immediate cause to the violence could be seen, the patient often had made a wish or request some time prior to the violent incidence that had not been responded to by staff. No systematic gender differences in violence were found, neither in frequency nor in seriousness.

Of the presenting psychiatric symptoms at intake only depression and paranoia were significantly correlated with violence during hospitalisation. Except dissociative disturbances, which were overrepresented in both serious and less-serious violent episodes among the girls, none of the ICD-10 diagnoses were significantly associated with violence. 38 of the patients had been violent prior to hospitalization, while 27 were violent during the stay at the ward. Contrary to research findings among adult psychiatric patients, violent episodes prior to hospitalisation did not predict violence during the inpatient period.

Educational goals
1. A second or third violent episode appears to be a warning sign for continued use of violence during inpatient stay. Our results suggest that intensive treatment of this small group of individuals, involved in the majority of violent incidents and/or the most serious violence, could significantly reduce both the total number of incidents of violence and of serious violence in adolescent psychiatric wards.
2. Violent behaviour in this adolescent psychiatric ward was mainly transactional; dependent on situation and context. Especially verbal or physical intervention by staff was important. Increased knowledge among staff about ways to communicate about behavioural corrections and restrictions could hopefully prevent some acting out episodes.

Correspondence

Mr Inge-Arne Teigset
Oslo University Hospital, Ullevaal
Gaustad, bygg 7
N-0407
Oslo
Norway
+47 22 02 92 20
inge-arne.teigset@kompetanse-senteret.no

Assessing workplace violence for home care workers in a consumer-driven, in-home care program

Paper

Lindsay Nakaishi, Helen Moss, Marc Weinstein, Nancy Perrin, Linda Rose, W. Kent Anger, Ginger Hanson, Nancy Glass
Johns Hopkins University School of Nursing, Baltimore, USA

Background

Oregon was the first state in the United States to use Medicaid (federal/state health program) funds for an in-home care program for seniors and people with disabilities—a landmark decision that other states continue to emulate. The program enables individuals to continue to live in their homes and communities by providing in-home assistance with daily living activities. There are three components within the in-home care system: homecare workers provide care to consumer employers, consumer employers receive the care services, and case managers mediate services.

Oregon's in-home care program is a consumer-driven model that provides an alternative to more costly institutionalized care, facilitates autonomy for the consumers, potentially improves care and quality of life for the consumer, and increases workforce opportunities for home care workers. However, the workplace setting within the consumer's home, the interdependent and complex relationship between the consumer employer and the homecare worker, and weak labor market position of homecare workers may render them vulnerable to workplace violence and sexual harassment. These social and employment issues cannot be resolved in the same manner as more typical employment health and safety issues. In this situation, the workplace is the consumer employer's home, the perpetrator is either the employer or is related to or friends with the employer, there are limited training initiatives aimed to prevent or respond to workplace violence or sexual harassment, and there are no state employment policies that protect or support a homecare worker experiencing workplace violence or sexual harassment.

With an aging population and the numerous initiatives focused on shifting care from nursing homes and long-term care facilities to community-based care, in-home care is the fastest-growing segment of the healthcare industry in the United States [1]. The challenges of providing homecare workers with a safe workplace free from sexual harassment and violence is critical for the health and safety of both consumers and workers. Workplace violence has also been associated with negative health and employment outcomes for the worker and poorer quality of care to the consumer [2-8]. Although investigators have begun to examine workplace violence in hospital and clinic settings [8-16], there is a paucity of research on prevention of workplace violence and/or sexual harassment for homecare workers. Abusive behaviors, perpetrated by the consumer employer or others in the consumer employer's home (e.g., family member or friend) are critical safety, employment and health issues facing homecare workers in the consumer-driven model. Johns Hopkins University and the Oregon Health and Science University partnered to investigate homecare workers' experiences of workplace violence and sexual harassment perpetrated by consumer employers (or others in consumer employers' homes) (5R01OH009080-02).

Methods

Relationships were developed with academic and community partners (e.g., state and local aging and disability experts at the Oregon Home Care Commission and the Service Employees International Union (SEIU) Local 503 representing the homecare workers). An advisory board comprised of homecare workers, consumer employers, advocates for consumers, SEIU Local 503 representatives, case managers and other staff from the DHS in-home care program, and members of the Oregon Home Care Commission was also formed to oversee the study. The study partners and advisory board facilitated recruitment and retention of study participants and provided guidance during the study design and implementation.

Both qualitative (e.g., focus groups and individual interviews) and quantitative (e.g., self-report survey) techniques were used within three self-selected populations, 1.) homecare workers, 2.) case managers and other DHS in-home care program employees and 3.) consumer employers. Separate focus groups were conducted with homecare workers and case managers. Individual interviews were conducted with all three groups. Before the focus group/interview guided discussion, participants completed self-administered, paper surveys. Two moderators were present for each discussion and each focus group/interview was digitally recorded and transcribed. The qualitative data were analyzed to determine trends and themes using QSR International's NVivo 8 software.

The qualitative data collection facilitated a more comprehensive understanding of the perspectives and nuances of homecare workers' experiences and included structured, audience-specific questions to guide a 1-2 hour, group discussion. Specific variables of interest included prevalence, definitions and examples of workplace violence and sexual harassment, barriers to a safe workplace, risk factors, and trainings received or desired. We also created audience-specific survey instruments that captured demographic information and quantified personal experiences or knowledge of workplace violence and sexual harassment. The surveys were self-administered prior to the beginning of the focus group/interview discussions.

We recruited from targeted areas across the state of Oregon that represented both urban and rural communities, through advertisements at training events and in SEIU Local 503 newsletters. Eighty-three homecare workers in six Oregon counties participated in six focus groups and four individual interviews with trained facilitators. The homecare worker participants were all females that provide in-home, direct care to consumers through the state's in-home care program (80.8% Caucasian, 50.6 mean age, 9.8 mean years of experience). Working with the Department of Human Services (DHS), Seniors and People with Disabilities (SPD) office, we recruited 99 case managers and other DHS in-home care program employees from the same six counties to participate in 12 focus group meetings (50.5% case managers, 92% Caucasian, 85.9% female). Eleven consumer employer participants were recruited with assistance from the Oregon Home Care Commission, the STEPS consumer employer training program and referrals from case managers (72.7% Caucasian, 72.7% female).

Results

Prevalence of workplace violence and sexual harassment
While the sample of homecare workers (n = 83) was not random, reports of abuse and harassment were common. Homecare workers reported experiencing incidents of workplace physical violence (44%), non-physical violence (65%), sexual violence (14%), and sexual harassment (41%). Homecare workers' reports of violence and sexual harassment were supported by data gathered from the questionnaires completed during the focus groups with case managers (n = 99). Most case managers received reports of home care workers experiencing workplace violence and sexual harassment perpetrated by the consumer employer (or others in the homes' of the consumer employers), including reports of consumer employer perpetration of physical violence (66%), non-physical violence (85%), sexual violence (27%) and sexual harassment (56%).

Definitions of workplace violence and sexual harassment provided during focus groups
During the focus groups and interviews with homecare workers, case managers and consumer employers, all agreed on common definitions and provided similar examples of abuse. All groups agreed that workplace violence includes incidents when homecare workers are threatened or assaulted in circumstances related to their work, involving any explicit or implicit challenge to their safety, well-being or health. Participants also agreed that sexual harassment is any unwanted, unreciprocated and unwelcomed behavior of a sexual nature that is offensive to the person involved, and causes the person to be threatened. In addition, the groups shared similar examples (Table 1).

Table 1: Exemplars of Workplace Violence and Sexual Harassment

	Examples
Physical Violence	• Slapping • Hitting • Lashing out • Stabbing • Kicking • Spitting
Non-Physical Violence	• Yelling and screaming • Name calling • Stalking • False accusations • Feigning a disability • Manipulation • Financial control • Threats of physical harm • Threats with weapons
Sexual Harassment	• Sexual remarks and propositions • Exposure to pornography • Exposure to masturbation • Exposure to nudity
Sexual Violence	• Inappropriate touching of a sexual nature • Groping breasts or buttocks • Rape

Barriers to prevention of workplace violence and sexual harassment
Participants from all three groups consistently mentioned the same primary barriers to preventing or responding to instances of workplace violence/sexual harassment:
• Economic climate — feeling the need to keep the job and health coverage, despite instances of violence.
• Accusations of abandonment — refusal to leave dangerous situations to avoid accusations of abandonment (penalized by loss of eligibility to provide in-home care).
• Confidentiality rules — homecare workers and case managers feared sharing instances of violence because of unclear confidentiality rules (breach of confidentiality results in loss of job).
• Lack of protective policies — only policies focused on preventing/responding to abuse of the consumer employer — none for the homecare worker.
• Lack of support — Case mangers' job is designed to support consumer employers, not the homecare workers.
• Nature of emotional labor — homecare workers often remained in abusive or dangerous environment because of personal bond developed with consumer employer.
• Training — lack of training for homecare workers, case managers and consumer employers.

Risk factors
Some of the primary variables that participants believed may increase risk for a consumer employer (or others in the consumer employer's home) to perpetrate violence included medication use, disease/diagnosis, alcohol or drug use, familial or intimate relations between the consumer employer and homecare worker (although familial relations was also mentioned as a variable that may decrease risk), history of abusive behaviors, performing personal care tasks, homecare worker's work experience and consumer employer's mental health status.

Training on workplace violence and sexual harassment
Only 16.9% of homecare worker participants (n = 83), 15.3% of case managers and other DHS in-home care program employee participants (n =99) and 0% of the consumer employer participants (n= 11) reported receiving training on preventing or responding to workplace violence/sexual harassment towards homecare workers. However, all three groups strongly agreed that there was a need for training in this area. Suggested components for the homecare worker-specific training included assertiveness, defining work boundaries, communication skills, identifying warning signs, how and where to access support resources, how to protect oneself from physical threats and de-escalation techniques.

Conclusion and Discussion

Qualitative and quantitative findings indicated that the majority of the homecare worker, case manager and consumer employer participants were aware of instances of homecare workers experiencing workplace

violence/sexual harassment perpetrated by the consumer employer (or others in the consumer employer's home). The participants were also in agreement on the types of violence homecare workers are experiencing, the in-home care program's barriers to a safe workplace and the risk factors affecting the incidence of abuse. In addition, the data informed us of the extreme lack of training for any of the parties involved in the in-home care program.

This study provides new insights into the challenges of providing a safe workplace environment for homecare workers. Although the participants did self-select, it is evident that workplace violence/sexual harassment does exist in the in-home care setting and it warrants further investigations. The preliminary data gathered from the focus groups/interviews and surveys will inform the development of a more extensive survey tool to be randomly distributed to a larger sample of female homecare workers in order to obtain a more accurate prevalence rate of workplace violence. Ultimately, the quantitative and qualitative data will guide the development of a homecare worker training that will aim to equip homecare workers with the skills necessary to prevent and respond to workplace violence and sexual harassment.

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Correspondence

Ms Nancy Glass
Johns Hopkins University School of Nursing
515 North Wolf Street
Baltimore, MD 21205
USA
+1 410 614 2849
nglass1@son.jhmi.edu

Health sector violence and abuse

Paper

Joy Adams-Jackson
Charles Darwin University, Darwin, Australia

Introduction

Health sector violence and aggression are issues of global significance for all health care workers. The nature of health care work necessitates close physical contact and for this reason nurses and other health care workers are vulnerable to threats and actual incidents of violence and aggression from their clients and other members of the public. While the potential for violence against nurses has always existed, current evidence suggests that it is increasing. Violence against health workers is anathema to fundamental notions of care-giving that assume a degree of acceptance and gratitude on the part of clients and patients.

The present study reflects on the issues of violence and abuse in the Australian Health Sector. A review of the extant literature on health sector violence in the Australian context reveals the tensions that exist between the dominant Occupational Health and Safety discourse and its focus on workplace health and safety regulations intended to provide safe work environments, and the failure to establish preventive alternatives for managing workplace violence and abuse.

Health sector violence is an important issue for all health sector employees, especially nurses who deal with the public on a regular 24-hour basis and who are frequently at the frontline of violent incidents. Broad definitions of workplace violence include physical and verbal abuse, threats and harassment against staff at the actual work facility and during their commute to and from work (St-Pierre and Holmes, 2008). While the issue of violence in the healthcare sector in relation to 'at risk' clients is well documented (St-Pierre and Holmes, 2008), less is understood about nurses' efforts to deal with workplace violence that is constrained by and widely accepted as ordinary workplace practice by many health organizations (Jackson, 1998).

The main objective of this paper is to critically examine the incidence of stalking as violence in the health sector, and determine why it and other forms of violence are an ongoing concern for health professionals. Both nationally and internationally, the issue of workplace violence arouses feelings of fear, anger and frustration among health professionals, particularly because of perceived management indifference and complacency towards the issue of workplace violence and staff health and safety.

Definitions of violence

While political, cultural and psychological factors can trigger acts of violence, violence is primarily a social or *anti-social* act *chosen* by some individuals who essentially understand the social parameters governing right and wrong social behaviour. According to Horsfall (1998) and Hoff (2010), violence constitutes behaviour for which the perpetrator is ultimately accountable.

As Hoff (2010) argues, traditional excuses based on cultural norms or cultural relativism such as references to aggressive instincts and mental illness are simply misplaced attributions. Despite this though, the judiciary sometimes continues to proffer a defence of aberrant behaviour to explain acts of violence. In New South Wales (NSW) Australia recently, a local magistrate dismissed a case against a violent offender who randomly and viciously attacked elderly pedestrians in a local mall; the magistrate ruled uncharacteristic behaviour due to depression. Disappointingly, the judiciary did not hold the perpetrator accountable for his actions.

Most contemporary violence literature (Everett and Gallop, 2000; Hoff, 2010) eschews socio-biological explanations of violence as something innate. Instead, psycho-socio-cultural and feminist interpretations shape our current understanding of violence. Importantly, violence involves the exertion of physical, psychological and emotional force over someone with the intention of disempowering, harming or controlling that person (Hoff, 2010).

Some definitions of harassment and stalking

By definition, stalking refers to a series of repeated and relentless attempts by someone to impose unwanted contact or communication on another, or as claimed, 'a new word for an old behaviour' (Mullen et al., 1999; Mullen et al., 2001: 9). The term first entered everyday parlance in the 1980s to describe the actions of fans who intruded into the lives of their famous idols (Purcell et al., 2004).

Stalking behaviours commonly involve following a victim or keeping them under surveillance; loitering around a victim's home or workplace or other places they frequent; subjecting a victim to unwanted attentions, such as frequent nuisance telephone calls, *inter alia*, designed to create a sense of fear and distress (Mullen et al., 2001; McIvor and Petch, 2006).
Stalking has emerged as a key social problem and one that especially affects mental health professionals due to the incidence of mental disorder among stalkers. Nevertheless, discourses of safety in relation to suicide and risk management tend to overshadow the significance of stalking and its impact on the occupational health and safety of mental health and other clinicians (McIvor and Petch, 2006).

Extent of the problem

An Australian Institute of Criminology Report (1999) suggests that the health sector is the most violent industry in the country (cited in Jones and Lyneham 2000). While healthcare professions are becoming more violent occupations in which to work (Rippon, 2000), it is important to differentiate threats and violence in hospitals or other health facilities from the relentless and persistent behaviours that define stalking (McIvor and Petch, 2006). For example, anecdotal reports from nursing staff in Australian mental health facilities indicate that instances of threatening and harassing behaviours, stalking and overt violence are common occurrences. Like all forms of abuse, the occurrence of workplace violence and abuse has a significant impact on the overall functioning of the victim (Rippon, 2000; McIvor and Petch, 2006). Hence the fear, anger, frustration and stress experienced by health sector workers following a violent incident (Sandberg et al., 2002), often leads to reduced work performance resulting in disruption to an otherwise functioning health-care service.

The NSW Health Department (Australia) supports a zero tolerance response to violence in the NSW Health Workplace. The Department's health policy guidelines affirm the right of staff, patients and others to work in or receive care in a 'therapeutic environment free from risks to their personal safety' (Policy and Framework Guidelines, 2003:2). Employers must provide a safe and secure work environment for all employees (Fisher, 1998). Yet despite this obligation, nurses often feel unsupported by employers who compound the assumption that violence and abuse are part of the job (Hoff, 2010), which ultimately leads to a sense of alienation. A culture of victim blaming commonly exists whereby fellow colleagues and management either directly or indirectly hold the victim responsible for provoking the hostility or violence, which exacerbates the sense of alienation. As well, blaming the victim allows colleagues to distance themselves from the reality of abuse or to believe rather erroneously that they are more competent or in some way better than their abused co-worker(s) (Fisher, 1998).

Why target health workers?

Hoff (2010) points out that violence and abuse of health care workers tends to fall along race, gender and class lines. Hoff explains that in general health and residential settings female staff are often the victims of unwanted sexual advances by both male clients and staff, and she reminds readers that nurses are frequently the recipients of verbal abuse from doctors also (Hoff and Slatin, 2006; Hoff, 2010). As well as the pervasive violence and abuse experienced by nurses and other generic health workers, the incidence of violence against female doctors is similarly widespread (Hoff, 2010), suggesting that all direct care providers are prime targets of abuse and violence.

Many factors contribute to stalking and other violent client behaviours. Some authors suggest that patients may hold unrealistic expectations about normal therapeutic relationships making terminating a therapeutic relationship difficult by evoking feelings of rejection and abandonment in the client (McIvor and Petch, 2006). In addition, delusional thinking and substance abuse generally underpin the actions of stalkers with a psychotic illness (Sandberg et al., 2002).

Mullen et al. (2001), comment on the relationship between stalker and victim, to determine whether the stalker is psychotic or non-psychotic, and identify some reasons behind the motivation and continuation of the behaviour. For organisational purposes, Mullen et al. developed a multi-axial classification of stalking and stalking behaviours to identify the following stalker characteristics:

1. The rejected stalker- who follows and ex-intimate, usually a previous sexual partner
2. The intimacy seeker- attempts to form a relationship with someone who has engaged his or her affections, and who is often mistakenly believed to already reciprocate that affection
3. The incompetent suitor- merely looking for a date or attempting to establish initial contact
4. The resentful stalker- aims to frighten the victim. The stalking emerges out of a desire for retribution for some actual or supposed injury
5. The predatory stalker- stalks preparatory to launching an attack, usually sexual in nature. (2001:11)

Former partners present a high risk of violence while strangers and acquaintances pose little risk (Rosenfeld, 2004; Mc Ewan et al., 2007; Resnick, 2007). This suggests in part that the stalker's proximity to the victim determines the presence or absence of violence.
Individuals who are frustrated by the system, who feel wrongly diagnosed, who believe that their rights as clients are violated in some way may focus their resentment and anger on an individual or organization, as demonstrated by the following case example.

The categorization of the 'resentful stalker' by Mullen et al. (2001), has particular significance for this paper because the client in the case example held an extremely high level of resentment against his local community mental health service, and blamed it for all his shortcomings. The authors state that the resentful stalker emerged from the current culture of 'claim and blame' and note that: *"Blaming and claiming have become a major element in the interactions between citizens and in particular, between individuals and what they perceive as the agents of power and control, be that government, big business or the professions"*. (Mullen et al., 2001:13)

The names of the client, staff and service location are concealed in the case example for privacy and confidentiality purposes. The case example draws on personal clinical experience.

Case example: John, an alcohol dependent personality disordered client

John is a 40 –year- old male with a long-term history of alcohol abuse and trouble with the police. He spent 3-months in a drug rehabilitation centre before returning to his home- town and family. Once home he began frequenting his old haunts and the local pub. After a short time and with increased drinking, his behaviour became more erratic and hostile towards the local community mental health service that he believed had misdiagnosed him. He took to writing a damning blog against members of the mental health service, printing copies of the blog and putting them under the front door of the community health centre and also delivering copies to various Drs Surgeries, the local member for parliament and the police. As time wore on, the content of the blog became more abusive, personal and threatening. He identified staff by name and directed his diatribes against them. He found staff telephone numbers and rang them in the middle of the night or very early in the morning. Some staff ignored John while those directly affected by his behaviour became more concerned. John claimed he had weapons that he was prepared to use on certain people. He followed some staff into the local town in a bid to find out the impact of his blogs. Senior management knew about all the problems. Despite this, they took no action and did not seem concerned about any of the threats or the very public damning of the health service and the impact this had on staff. John continued with his blog for nearly 3- years.

All efforts by clinicians to establish contractual boundaries or prevent John from attending the local service where he had grievances were overturned. Some staff refused to have any contact with him unless back-up staff were present. On several occasions staff called police to remove him from the premises, on one occasion after he settled in the community health centre waiting room to consume bottles of alcohol. John was undeterred by medical staff or police personnel. Despite convictions for armed robbery, senior management ignored staff complaints about John's various threats to shoot or harm staff.

What this case example illustrates is that management ignored their zero tolerance policy directives. At the outset, boundary problems were evident, yet senior management actions magnified rather than minimised the problems. Throughout the zero tolerance document (developed by NSW Health), the implicit assumption is that violence is not an accepted aspect of the job and that management have a duty of care to respond appropriately when an incident is reported. They neglected to do this.

The harassment and stalking behaviours experienced by staff of the mental health service had a significant impact on members of the team, to the extent that a senior staff member left the service and some of those who remained felt a deep sense of powerlessness, disenchantment and resentment at management's overall lack of support and protection (Sandberg et al., 2002).

Despite Australian Occupational Health and Safety legislation, violent incidents continue wherever nurses and other health sector employees work. In both the hospital ward and in community settings, health personnel face real dangers of workplace violence. An earlier paper by Fisher et al., (1995), indicated that the most likely response from employers to reports of violent incidents was to ignore the problem and take no action. Fifteen years on (as noted from the case study), little has changed. Employer inaction does not inspire worker confidence to feel supported and protected while performing their duties.

Implications for the health sector

Health sector workers are frequent targets of violence as healthcare facilities become increasingly violent places in which to work. Stalking has emerged as a significant yet under recognised social and workplace problem; whereby health professionals are at greater risk of unwanted and intrusive behaviours perpetrated by patients and clients. While the literature identifies explicit threats, property damage and physical assaults in incidents of health sector violence, the prevalent crime of stalking remains under-reported, under-recognised and inappropriately managed.

Abusive encounters in the health-sector are both troubling and disruptive, so it is important to recognise the prevalence of them and acknowledge the distress they cause healthcare professionals. At the organisational level it is essential to guarantee that suitable policies exist to create staff awareness and to reduce the risk of all violent behaviour. As well as policies to raise awareness of violence, staff must feel confident that in the event of any violent incident, they have management support and protection. Staff must have protocols for dealing with violent behaviours and an environment that upholds zero tolerance. Management support is crucial for the success of a zero tolerance approach. If management support is not apparent, the approach will not work. Management must therefore demonstrate commitment to their workforce and lead by example.

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Correspondence

Mr Joy Adams-Jackson
Charles Darwin University
PO Box U366
0815
Darwin
Australia
+61409129700
joy@unswalumni.com

Rethinking violence in long-term residential care for the elderly: Learning from international comparative research

Paper

Albert Banerjee, Tamara Daly, Hugh Armstrong, Pat Armstrong, Stirling LaFrance, Marta Szebehely
York University, Toronto, Canada

Abstract

This paper presents the findings of a mixed method, international comparative study of long-term residential care for the elderly across three Canadian provinces (Manitoba, Nova Scotia, and Ontario) and four Scandinavian countries (Denmark, Finland, Norway, and Sweden). This paper focuses on the experience of Canadian personal support workers (PSWs) who are on the front lines of care. Our findings are deeply troubling. The study documents violence as a constant and ongoing part of their work. The violence PSWs experience is physical, verbal and sexual. Ninety percent of the sample had experienced some form of physical violence on the job and nearly half (43%) experienced physical violence every day. Focused discussions revealed a culture of tolerance, where violence was taken to be a routine part of the job. Nevertheless, comparisons with Scandinavian countries clearly indicate that the frequency of violence in Canadian long-term care is extraordinary, with Canad ian PSWs being seven times more likely to experience violence than Nordic workers. Canadian workers identified working conditions and, in particular, inadequate staffing as one of the main reasons for the ongoing violence. Our study found important differences around workload, autonomy and exhaustion. Canadian PSWs were twice as likely to end the day feeling physically exhausted, three times as likely to experience back pain, and four times as likely to be mentally exhausted as their Scandinavian counterparts. This paper theorizes Canadian working conditions as a form of structural violence (Farmer, 1996), and in doing so contributes to shifting perceptions of violence from the interpersonal level to the structural level, where they may be addressed through policy and funding mechanisms as well as organization of labour practices in the workplace.

Educational goals
1. Violence in the workplace has important structural preconditions that can be addressed through policy, funding, and workplace mechanisms.
2. Front-line careworkers have important knowledge contributions that may alleviate violence but are typically ignored at the level of policy development and institutional organization.

Correspondence

Mr Albert Banerjee
York University
4700 Keele St.
M3J 1P3
Toronto
Canada
+1 416 897 91 52
balbertb@yorku.ca

Contributing factors to workplace violence: Iranian emergency department nurses' perspectives

Paper

Mohammad Esmaeilpour, Mahvash Salsali, Fazlollah Ahmady
Gilan University of Medical Science, Rasht, Iran

Abstract

Background

Violence both physical and verbal may have destructive effects on health care systems. The identification of causes of violence will help health care providers especially nurses to develop prevention protocols and improve nurses' quality of work life as well as quality of patients care. In should be noted that in contrast to western countries, little is known about difficulties that developing countries nurses face to workplace violence. To bridge the gap of knowledge, a research was conducted to explore Emergency Department (ED) nurses' perspectives regarding contributive factors to workplace violence in Iran.

Method

A self-reported questionnaire on workplace violence in the health sector provided by International Labor office, ICN, WHO, and PSI was employed to reach the study aim. The last portion of the questionnaire consisted of 3 open-ended questions. The questionnaire was filled in by 152 nurses working in 11 ED's of teaching hospitals affiliated to Tehran University of Medical Sciences. Bachelor's degree nurses who had at least one year of working experience in EDs and faced physical or verbal violence were chosen to participate in the study. In this report quantitative content analysis of the participants' responses to the 3-open-ended were presented.

Findings

According to the participants, the contributive factors to violence consisted of the interference of people who accompany patients to EDs in nursing cares, waiting for being visited by physicians, over-crowding of health care facilities, EDs inefficient security personnel, nurses shortage, lack of support from hospital managers as well as proper legislations to defend nurses, patients' low socioeconomic level, shortage of equipments and the negative public image of nursing. In addition, improving public awareness of nurses' importance in the health care system, improving the level of nurses' workplace safety, post-incident support by managers, coordinating between educational and therapeutic roles in health care facilities, providing welfare facilities for nurses were indicated as measures to reduce the potential of violence in EDs.

Conclusion

Hard working conditions and dangerous environment factors lead to the nurses' burnout and physical as well as emotional pressures. Some Iranian cultural factors were among the contributing factors to violence in EDs. Establishing the violence management team to improve nurses safety in EDs and facilitate policy making to defend nurses are recommended. Providing educational programmes to public as well as EDs security personnel regarding the violence management is needed.

Educational goals
1. Establishing the violence management team.
2. Providing educational programmes to all.

Correspondence

Mr Mohammad Esmaeilpour
Gilan University of Medical Science
Azoody
4144668164
Rasht
Iran
+98 142 523 62 63
esmaeil2009@hotmail.com

Construction of an assessment and training instrument for intervention with aggressive psychiatric patients

Paper

Lois Biggin Moylan
Molloy College, Rockville Centre, New York, USA

Introduction

The use of physical restraints as an intervention for controlling patient aggression in the acute care psychiatric setting has significant ethical, legal and therapeutic implications. Ethical treatment of those with cognitive and/or emotional impairment demands that these patients be treated with respect and dignity and that their right to autonomy and safety be safeguarded. These ethical standards relating to use of physical restraint are explicated by the professional organizations of nurses and of other mental health workers (American Nurses Association, 2001; American Psychiatric Nurses Association, 2000; National Association of State Mental Health Program Directors, 1999). All of these bodies call for the least restrictive means of intervention with the aggressive patient that is necessary to maintain safety. Because the use of restraint can cause harm, and in some cases, death to a patient, (Gordon, Hindley, Marsden & Shivayogii, 1999; Paterson & Duxbury, 2007) this intervention should be avoided if any other therapeutic approach can be successful in de-escalating a patient's aggression. Conversely, deciding to restrain a patient too late, after injury to self or others has occurred, can have greater negative consequences (Slovenko, 2006; Yorker, 1995). For this reason, it is of utmost importance that nurses are able to accurately assess a patient's aggressive behavior and are able to identify at what point no other less restrictive measures of intervention would be effective and restraint of the patient would be the appropriate intervention in order to provide safety.

This presentation will describe the development of an instrument, the Moylan Assessment of Progressive Aggression Tool (MAPAT), which is currently in use to assess nurses' decision making with aggressive psychiatric patients. The instrument is an audio-visual representation of a patient (portrayed by a professional actor) demonstrating progressive aggression.

Construction of the Instrument

Prior to creating the instrument, literature was reviewed from the disciplines of nursing, medicine and psychology relating to progression of aggression. Sources describing the theory of aggression progression, including biological and behavioral components, and previous studies were examined. The literature reported that, although some aggressive incidents erupt spontaneously, aggression in psychiatric patients most often follows a systematic pattern and the point at which actual violence occurs is predictable. Proximal predictions of aggression are based on the progressive escalation of behaviors from anxiety and agitation through violent acting out in the cycle of aggression. These findings provided the basis for action and verbalizations depicted in the video.

Ten situations describing patient behaviors, which reflected the theoretical constructs and clinical data related to levels of patient aggression, were recorded on ten five inch by eight-inch index cards. The context is that of a patient interacting with a nurse in an acute care psychiatric setting. The content of these cards ranged from a description of calm patient behavior through increasing agitation to attack and, ultimately, strangulation of the nurse. Each card contained a description of the patient's physical appearance and motor movements, while six of the situations contained verbalizations. The character of the verbalizations was described on the cards, but not the specific wording so as not to reveal the sequence. For example, the cards stated "anxious verbalization", "sarcastic verbalization", "cursing", "general threatening verbalization" and "verbalization indicating a specific threat". Ten Advanced Practice Master's prepared nurses (Clinical Nurse Specialists and Nurse Practitioners) in psychiatric mental health, who had extensive experience in acute care clinical psychiatric practice, which included the restraining of aggressive patients,

were selected for testing and evaluation of the tool. These specialists were first asked to identify the progression of aggression by ordering the ten patient situation cards.

The following procedure was used: In separate individual tests, the ten situation cards were given to the clinical experts in random order. Each Advanced Practice Nurse was asked to read each card and arrange the cards on a desk, face down, in order from least indicative of aggression and potential violence through increasing levels of aggression and danger to most aggressive and indicative of potential violence. After the clinical expert nurse indicated that she had completed the task, the cards were turned over in the presence of the designer of the instrument. The nurse specialist then recorded her initials on the back of the card with the rank number in which she had placed it. Each of the nurse specialists was given a new identical set of cards so that she would not be aware of the other raters' ordering of the cards. After all ten expert nurses performed the order ranking, the results were compared. In each case the results were identical, giving unanimous agreement with each other in the assessment of the progression of aggression. Their ranking also was congruent with the progression and escalation of aggression discussed theoretically in the literature, the clinical reports and research reported in the literature, and the instrument designer's own clinical experience as a Clinical Specialist.

The procedure used is congruent with the scalogram technique developed by Guttman (Dawis, 1987) which ascertains unidimensionality where there is an orderly stepwise progression for both individuals and items. Since a perfectly ordered stepwise progression occurred, there was no need to apply the mathematical formula to obtain the coefficient of reproducibility since 100% reproducibility was achieved. The ordered situation cards became the action for the MAPAT video and specific words were added for the dialogue. The video time sequence covers a period of 0 to 300 seconds yielding a ratio level of measure. The time elapse is digitally displayed at the bottom of the screen.

After the filming and editing were concluded, the original clinical specialists were asked to view the video and, using the same situation cards, match each card to the behavior being portrayed on the video screen. Each card was placed face down by the specialist at the time she assessed the behavior was occurring. This was done to validate that the progression of aggression assessed on the cards was accurately displayed in the video. The cards were then turned over by the designer of the instrument. Again, there was complete agreement among the specialists and each had placed the cards in the same order as they had been placed in the original testing. One final measure was obtained from the nurse specialists. Each was asked to identify the point at which they judged physical restraint would be the only safe and appropriate response and would meet legal and ethical standards. All selected a sequence occurring within a six second interval (seconds 239 through 244) of the 300 second video during which the patient forcefully struck the desk, was loudly making a specific physical threat to the nurse and advancing toward her.

Validity

The procedure described above establishes the content validity of the MAPAT. In establishing content validity, Lo Biondo-Wood and Haber (2006) state that, after developing the measurement tool, it should be "submitted to a panel of judges considered to be experts about this concept" (p 339). Additionally, a source published after the development of the instrument provided further support for the portrayal of the progression depicted in the MAPAT. Maier (1996), reports five stages of arousal in the process of escalation. For each stage the author describes the patient's behavior and the associated feelings of the patient. In stage one the patient begins to show minor motor changes in the jaw and fists and feels a sense of frustration. At stage two, hostility is evident and is accompanied by verbal threats or abuse. This is followed by evident anger with increased major motor activity in stage three. In the fourth stage, feelings of rage are expressed in physical aggression. Following the acting out of aggression, there is a state of exhaustion. The MAPAT depicts each of the first four stages in sequence with incremental changes within each of these stages.

Reliability

In order to establish test-retest reliability, the MAPAT was administered to 24 graduate nursing students who worked in acute care psychiatry and were pursuing advanced practice degrees in the field of psychiatric/mental health nursing. Two weeks later the same subjects were retested. The MAPAT scores for each subject were subjected to analysis using the Pearson Product-moment procedure. An r of .891 resulted. Additional test-retest reliability was obtained from subjects participating in the decision to restrain study. Using the Pearson Product-moment procedure, the MAPAT scores of the subjects yielded an r of .879. The findings in relation to both of test-retest studies are congruent with a level of reliability acceptable for use in a research study (Carmines & Zeller, 1987). Due to the nature of the MAPAT, in which only one measure (time selection) is chosen by the subject, internal consistency reliability does not apply. In addition to obtaining validity and reliability measures, the final version of the instrument and the history of its

development were submitted to a psychometric consultant for technical review. The instrument was judged to meet acceptable psychometric standards.

Potential Limitations of the Validity of the Instrument

Criterion validity would be difficult to ascertain as situations related to real life application of restraints would be difficult to measure as they are unpredictable, dangerous and require immediate action in an environment where patient confidentiality is protected. Additionally, although video simulations are used routinely to assess and test decision making in volatile situations by law enforcement (Bennell, Jones & Corey, 2007; Correll, Park, Judd, Wittenbrink, Sadler & Keyes, 2007), studies demonstrating criterion validity of the videos are not reported in the literature.

Other factors which may negatively impact validity and may limit generalizations of the findings include variation in nurses' responses related to the size, gender, race and other physical characteristics of patients which differ from those of the medium sized, white male depicted in the video. Further study of this phenomenon is needed.

Additionally, as aggression progresses, the speed of the aggressor's actions increases rapidly, requiring an immediate response from the nurse/subject in stopping the video. However, this is congruent with an actual clinical occurrence of a violent incident.

Administration of the Instrument

To ensure that potential subjects would focus only on the patient behavior being displayed on the video, clear and explicit written directions were developed. In these, the subject is told that the nurse in the video will not intervene effectively, using less restrictive therapeutic interventions as would be appropriate at earlier stages of escalating aggression. The subject is told that the purpose of the video is to depict escalating aggression in a patient and that the subject will make the decision as to the exact point when restraint is needed. Therefore, they should focus solely on the patient's behavior. The subject is instructed to turn off the video at the exact moment he/she makes the decision that physical restraint of the patient is the only appropriate intervention needed to maintain safety. The written instructions are reinforced verbally by the researcher prior to administration of the instrument. The subject is given the remote control and shown the stop button to push as soon as he/she has decided that restraint is the only safe intervention option. The video is then started by the researcher who moves some distance behind the subject to avoid distraction. After the subject stops the video, he/she then records the elapsed time displayed on the bottom of the video on the MAPAT form.

Scoring of the Instrument

The score on the MAPAT is obtained by converting the minutes and seconds into seconds, providing a ratio level of measure with a mathematically possible 0 to 300 value. However, realistically the range is smaller as nurses would not make a decision to restrain a patient who is calm or very mildly agitated.

Conclusion

This instrument has been used in a prior study of nurses' decision making related to the use of restraint with aggressive psychiatric patients and is currently in use in an ongoing study (Moylan, 2009). This paper provides a description of the process of the development of the instrument. Validity and reliability of the instrument are presented. A brief overview of findings from the prior study using the instrument will be presented to elucidate the instrument's usefulness in actual practice.

In addition to its use for research, implications for potential use as a training tool are discussed. Specifically, it can be used to educate nurses about the behaviors and physical manifestations associated with each of the phases of escalating aggression. The instrument also serves as an assessment tool for evaluating nurses' knowledge of appropriate supportive interventions during the different phases of escalation as well as identification of behaviors which require restraint use in order to provide safety for the patient and staff. The instrument allows nurses to learn and perfect their skills in a safe environment. Its value in orienting nurses who are beginning psychiatric practice and use for retraining when indicated are discussed.

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Educational goals

After attending the presentation of Construction of an Assessment and Training Instrument for Intervention with Aggressive Psychiatric Patients

1. The learner will be able to identify the phases of progressive aggression in a psychiatric patient exhibiting escalating aggressive behavior and appropriate therapeutic responses to these.
2. The learner will recognize the need for in-depth education and training of psychiatric nurses in relation to the maintenance of a therapeutic and safe environment in acute care psychiatry.

Correspondence

Mrs Lois Biggin Moylan
Molloy College
1000 Hempstead Ave
11571-5002
Rockville Centre, New York
USA
+1 516 678 5000 ext 6867
Lmoylan@Molloy.edu

Investigation of the development of a 'career' of aggressive behaviour by people with learning disabilities

Paper

Andrew Lovell, Joanne Skellern
University of Chester, Chester, United Kingdom

Introduction

An initial survey (Skellern & Lovell, 2008) revealed the extent of violence perpetrated by some people with learning disabilities to be greater than previously recognized. A subsequent study presented at the 6th European Congress on Violence in Clinical Psychiatry in Stockholm in October 2009 discussed professionals' experience of violence. This study, the third of the trilogy by the researchers into violence and aggression and people with learning disabilities, explored the development of violence in the lives of a group of people with learning disabilities currently residing in settings of varying security. A case study approach, accumulating evidence from clinical records and interviews with service users, constituted this third study of violence in the context of learning disability. This study draws on the work of Emerson and Bromley (1995), in terms of selection of the sample, who described three aspects to challenging behaviour:

a) "…has at some time caused injury to the person themselves or others which has required immediate medical treatment or destroyed their immediate living or working environment".
b) "…occurs at least once a week and requires the intervention of more than one member of staff to control, or places them in danger, or causes damage which could not be rectified by care staff, or causes more than one hour of disruption".
c) "…occurs at least daily and causes more than a few minutes of disruption" (p.389-90).

This three-pronged approach has been applied in this study, in our consideration of what constitutes violence and aggression, so that the presence of one or more of these aspects fulfils this requirement, although it is acknowledged that the two terms, violence and challenging behaviour, are not synonymous.

The specific aims of the study were to explore the development of violence & aggression over time in the lives of a group of individuals with learning disabilities, utilizing the concept of 'career' (Lovell, 2008), to analyse how individuals with learning disabilities with such a history, understood and explained such behaviour.

Literature Review

The consensus around violence within NHS settings remains that it is unacceptable under no circumstances, successive campaigns since the zero tolerance strategy of the 1990s continuing to emphasize the need for its eradication within the statutory and independent sectors. Totsika et al (2008) interviewed care staff to identify the persistence of challenging behaviours by people with learning disabilities and reported 'serious/controlled' behaviours (79%), physical attacks (70%) and self-injury (47%) to be the highest rates. Owen et al (1998), in a study examining frequency and type of violent and aggressive behaviours in psychiatric and primary care units, differentiated factors to do with the individual, environment and staffing. Individual issues comprised diagnosis, history, formal/informal status and substance misuse, whereas environmental concerns related to overcrowding, mealtimes and environmental stress. Finally, concerns about staffing revolved around role uncertainty, use of bank staff and lack of training. The most recent figures from the NHS Security Management Service (2009) reveal nearly 55,000 physical assaults on NHS staff during 2008-9, slightly lower than the previous year. Violence within mental health and learning disability services, however, continues to constitute the most significant number, just under 39,000 incidents, far higher than those recorded in the acute, ambulance and primary care sectors combined (a little over 15,000), but a reduction of about 10% from the 2004/5 figures (NHS SMS, 2009). Staff perceptions of aggressive clients has been tentatively linked to their cognitive and emotional responses to

the aggression (Ryan et al., 2008). Interestingly, in terms of attributed reasons for violence, there is evidence that service users regard external factors (e.g. inter-personal conflict) as more pronounced whilst staff are more likely to cite internal factors (e.g. symptom of psychosis) as most relevant (Nolan et al., 2009). Evidence from the second study by the researchers, of violence from the professionals perspective however, suggests violence by people with learning disabilities is regarded somewhat differently by NHS direct care staff than violence perpetrated by others. This research will be submitted for publication later this year (2010) and prompted the need to investigate the perspective of the individual with a learning disability.

Aims and Objectives

The aim of the research study was to explore the development of aggression over time in the lives of a group of individuals with learning disabilities.

Two specific objectives:
• To analyse how individuals with learning disabilities with a history of aggression and violence understand and explain such behaviour.
• To examine incidents of violent behaviour recorded in clinical documentation.

Methodology

An approach to the data, whereby evidence was collected from written and spoken sources, converted into a chronological case record and then into a case study through the addition of analytical insight, constituted the research design. Data was collected through interviews with a purposively selected sample of 30 individuals with a history of violence, residing in areas of varying levels of security and currently in receipt of services by a number of organisations participating in the research study. The questions focused on the individual's background and experience of violence, primarily, though not exclusively, as a perpetrator. Additionally, clinical case note material relating to the selected sample with a particular focus on recorded incidents of violence, was examined, specifically the recorded incidents of aggression, attributed reasons and general comments on the circumstances. This approach, utilizing the concept of 'career' (Lovell, 2008) as a means of exploring the way in which aggressive and violent behaviour became integrated into the lives of a group of individuals with learning disabilities, set out to explore the concept's pertinence to the relationship between learning disability and violence. The organisation and analysis of the data was supported by the computer software package MAXqda and the emergent themes were considered in terms of the 'career', whereby violence became progressively more entrenched within the individuals' lives.

Ethical considerations

The study does involve a recognized vulnerable group, people with a learning disability, as research participants. The researchers acknowledge that this is a complex and sensitive area, one which is often overlooked during research. However, this is the third of three research projects into the subject of violence and aggression by this particular research team and it is felt that it would be an injustice if the voice of the service users were not included in the trilogy. Therefore extensive consideration was given to the aspects of access to participants, informed consent and confidentiality. Ethical approval was sought and granted from both the University ethics committee and also IRAS, the Integrated Research Application System. The researchers, furthermore, would like to draw attention to violent behaviour being only one aspect of the individual's life, albeit the one that is the primary interest of this research project; the rest of the life is likely to involve a number of activities, complex relationships and interests, with little, if any, connection with aggression or violence.

Results

Initial results suggest that violence is a strategy learnt early in the lives of the participants and that it has always been a significant feature in their background. There is also an issue around how the learning disability influences the manifestation of violence in this population, an area in need of further exploration and research.

Conclusions

This study presents possible theory development in relation to learning disability and violence and the subsequent implications for health policy in terms of community interventions and avoidance of unnecessary detention.

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Correspondence

Mr Andrew Lovell
University of Chester
Parkgate Road
CH1 4BJ
Chester
United Kingdom
+44 1244 511 631
a.lovell@chester.ac.uk

Patient-related violence at triage: A qualitative descriptive study

Paper

Jacqueline Pich
University of Newcastle - School of Nursing & Midwifery, Callaghan, Newcastle, Australia

Introduction

In 1992, the largest number of non-fatal workplace assaults in the United States occurred between nursing staff and patients (Fisher & Gunnison, 2001). Recent figures estimate that Australian nurses are four times more likely to suffer an assault than those in the general workforce (Hegney, Eley, Plank, Buikstra & Parker, 2006) and twice as likely to experience work-related crime than other healthcare workers (Gallant-Roman, 2008). In the United Kingdom the prevalence of episodes of violence from patients is also reported to be escalating (Paniagua, Bond & Thompson, 2009). The phenomenon of workplace violence has been identified as one of the most complex and dangerous hazards facing the nursing profession today (Estryn-Behar, van der Heijden, Camerino, Fry, Le Nezet, Conway & Hasselhorn, 2008).

Violence in healthcare has been defined as "incidents where staff are abused, threatened or assaulted in circumstances relating to their work…involving an explicit or implicit challenge to their safety, well-being or health" (Mayhew & Chappell, 2005, p.346). Violence includes verbal abuse, physical threats and assault and emotional abuse (Lyneham, 2000). The specialities of emergency, aged care and mental health nursing have reported the highest prevalence of violence (Estryn-Behar et al, 2008)

Studies have found that violence has become an accepted part of the job for many nurses (Ray, 2007) with verbal and physical abuse regarded as just another occupational hazard (McKinnon & Cross, 2008). There is widespread acceptance amongst nurses that episodes of violence are unavoidable (Ray, 2007), despite their potentially life-threatening and life-altering nature (Jones & Lyneham, 2000). It has been suggested that this attitude perpetuates a normalisation of violence, which then becomes embedded in workplace culture (Jackson, Clare & Mannix, 2002).

The effects of such violence are not only significant physically and psychologically for the nurses involved but represent a heavy financial cost for employers in terms of lost productivity and workers' compensation claims (Lyneham, 2000).

Methods

This study was conducted in the Emergency Department (ED) of a tertiary referral and teaching hospital in regional New South Wales, Australia. The department regularly records in excess of 5,000 presentations per month.

Six triage nurses were interviewed in August-September 2008 about their experiences with patient-related violence in their workplace during the preceding month. Participants were selected using purposive sampling based on their clinical role (triage) (Streubert & Carpenter, 1995), and a semi-structured interview schedule was employed. Field notes taken at the time of the interviews were used to augment the transcripts.

Findings were verified with participants to ensure accuracy and validate results. Data were analysed using a qualitative descriptive method to identify emergent themes (Sandelowski, 2000). These findings were discussed with reference to the literature on the subject.

Results

The analysis of transcribed interviews resulted in identification of several themes described in more detail below.

Patient-related violence was reported by all participants at an average of one episode per day: *"I would say it is almost on a daily basis"* (participant 2). There was a perception that these episodes were an inevitable part of the job and were increasing in both frequency and intensity: *"I think anecdotally it is probably getting worse"* (participant 2).

Physical abuse

Four participants reported experiencing physical abuse, which resulted in two of them sustaining injuries: *"…the minute he kicked out or hit and just managed to get me in the chest"* (participant 4). The types of physical violence experienced included being kicked, slapped and hit by patients and having the safety glass at the triage counter punched. Participants reported being confronted by both traditional and opportunistic weapons including a knife, chair and sharps: *"…the knife actually went through the tiny little hole at triage and it came flying in"* (participant 4).

Verbal abuse

All participants reported experiencing verbal abuse with swearing being the most common type. Other forms included threats, shouting, making unreasonable demands, insulting, intimidation, taunting and berating. Participant 2 stated: *"Being sworn at – um - people stepping into your personal space – making unreasonable demands- that kind of thing"*. Participant 4 spoke of being fearful after her shift *"…I have been escorted to my car a few times by security because I was just a bit nervous"*.

The impact of violent behaviour

1. Professional. Participants talked about questioning their personal commitment to the job and doubting their professional skills. Many considered moving to what they perceived as a "less stressful" nursing environment or leaving the profession altogether. They also referred to a loss of empathy: *"it is hard to be empathetic when someone is abusing you using the f word"* (participant 5).
2. Personal. The negative emotions expressed by participants to describe their feelings revealed a sense of powerlessness and hopelessness, for example: *"Horrible - absolutely horrible - I feel inside – um – degraded"* (participant 5).

Antecedents and precipitating factors

Long waiting times were reported by all participants as a major risk factor for episodes of patient-related violence: *"Waiting times. I think that is probably the biggest one"* (participant 2). The most significant risk factor reported by participants was high patient volume in the department; particularly the afternoon shift, weekends and during winter. Unrealistic expectations of the workings of the department, especially during periods of peak demand, were also thought to contribute to patient-related violence.

Alcohol and substance misuse were thought to have a significant impact on the likelihood of patients escalating their behaviour and becoming violent: *"…alcohol is a big one – we get lots and lots of abuse"* (participant 2). Mental health patients were identified as a high risk group due to both the unpredictability of their behaviour and the lack of training and experience of the participants in their management: *"none of us…have any mental health training"* (participant 5). The majority of participants felt that both males and females were involved in patient-related violence and that females were becoming more aggressive: *"we get a lot more fights now with women who have been involved with alcohol…than we used to"* (participant 6).

Some nurses were able to recognise cues in patients at risk of escalating to violence and were able to employ de-escalation strategies. Some participants expressed concern that other nurses contributed to episodes of violence: *"it is their deliverance and their tone…I can see how people can construe that as being a little bit rude and condescending"* (participant 4).

Organisational strategies

Security guards and duress alarms were identified as the principal employer responses in combating patient-related workplace violence, together with workplace design. For example safety glass built into the triage counter and restricted access to the department.

All participants were aware of the existence of a Zero Tolerance policy towards violence but felt it was ineffective in managing the problem of patient-related violence: *"…really what person who has a tendency to become a little agitated is likely to read that sign and say zero tolerance – what does tolerance mean?"* (participant 4). Nurses indicated that they were required to cope with such incidents daily in their department notwithstanding the policy on the shelf.

Training such as Aggression Minimisation is a mandatory requirement in New South Wales healthcare; however only three participants had completed partial training: *"We don't actually have like formal training with regards to that – no"* (participant 1).

Reporting

Participants' comments on reporting indicated that the majority of incidents were not reported: *"we are supposed to fill it out (reports) but we just don't have the time and it is not user friendly"* (participant 5). While participants acknowledged the need for reporting they cited barriers such as: time constraints, lack of response from management, a non-user friendly, lengthy reporting system and the high frequency of violent episodes.

Coping mechanisms

Informal debriefing with colleagues or family and friends was the method adopted by all participants: *"Just debriefing with other people – other staff – looking after them - making sure they are ok – you just laugh it off"* (participant 6). Formal debriefing was not offered in relation to violent episodes; however participants felt that it should be mandatory. A workplace culture of accepting violence as part of the job meant that the nurses felt they should be able to cope and get on with the job: *"there is that expectation – we should be able to hack it…but that is not the point"* (participant 2).

Discussion

In this study, verbal abuse was reported by all participants with swearing being the most common form of abuse. Up to 82% of nurses across a range of clinical environments, including the ED, are thought to experience verbal abuse in their workplace (Farrell, Bobrowski & Bobrowski, 2006). Swearing has been identified as the most widespread and violent form of verbal abuse (Crilly, Chaboyer & Creedy, 2004; Stone & Hazelton, 2008).

The types of physical violence detailed by the participants are also reported in the literature. This includes the use of weapons such as knives (Ferns, 2005) and hospital equipment, for example syringes, which are often used against nurses due to their accessibility and availability (Lyneham, 2000; Ferns, 2005). Overt behaviors or symbolic violence designed to intimidate or threaten, such as punching the glass screen at the triage counter, are also discussed (Winstanley & Whittington, 2004).

Substance abuse and in particular alcohol intoxication have been previously reported to be associated with an increased risk of violent behaviour in patients (Catlette, 2005), and were implicated in over 42% of all violent episodes in one Australian study (Lyneham, 2000). A causal link has been identified between alcohol use and aggression (Ferns & Cork, 2008) as it is known to decrease tolerance in frustrating situations (Lyneham, 2000) and incite violent, abusive, threatening and unpredictable behaviour in patients (Ferns, 2005).

Patients with a dual-diagnosis of substance abuse and schizophrenia have been implicated as posing an increased risk of violent behaviour (McKinnon & Cross, 2008; Duxbury & Whittington, 2005). Studies have linked serious mental illnesses such as schizophrenia to an increased risk of violence, with sufferers up to two to three times more likely to exhibit violent behaviour than the general population (Friedman, 2006). Lyneham (2000) proposed a link between violent behaviour and lower socio-economic status, which is often linked to other risk factors such as mental health issues and substance abuse (Gallant-Roman, 2008). Many ED nurses lack mental health nursing experience and skills which has the potential to exacerbate potentially violent situations (Jones & Lyneham, 2000).

Excessive waiting times are consistently cited as a risk factor for patient-related violence (Pich, Hazelton, Sundin & Kable, 2010; Jones & Lyneham, 2000). Other related antecedents include the busy and overcrowded nature of the ED (Hodge & Marshall, 2007) and a lack of communication on the part of staff (Lau, Magarey ,& McCutcheon, 2004). Studies have revealed that many patients have unrealistically high expectations of nurses, and when these expectations are not met the resultant anger is usually directed towards nurses (Jackson et al, 2002).

Patient-related violence is more common outside normal working hours (Ferns, 2005), and during the afternoon shift (1500-2300) (approximately 40 percent of all assaults) (Dalphond, Gessner, Giblin, Hijazzi & Love, 2000), which is consistent with the findings of this study.

Verbal abuse has been associated with long lasting psychological reactions (Gerberich, Church, McGovern, Hansen, Nachreiner, Geisser, Ryan, Mongin, & Watt, 2004). These range from feelings of guilt and self-doubt, (Arnetz & Arnetz, 2001); to anger and powerlessness, (Astrom, Karlsson, Sandvide, Bucht, Eisemann, Norberg, & Saveman, 2004); and post traumatic stress disorder (Camerino, Estryn-Behar, Conway, van Der Heijden, & Hasselhorn, 2008). Despite this, informal debriefing with colleagues was the most common coping mechanism referred to in the literature (Astrom et al, 2004).

A lack of debriefing services offered by employers is highlighted in the literature; with nurses expressing the belief that debriefing after stressful incidents should be mandatory rather than optional and be conducted by professionals in the area (Ross-Adjie, Leslie & Gillman, 2007). An Australian study of ED nurses found that 52% were never offered support by management following a significant episode of violence (Lyneham, 2000).

Access to the ED has been identified as a major source of concern for nurses (Catlette, 2005) due to its accessibility to the general public (Phillips, 2007). In response security provisions such as increased personnel, the use of duress alarms together with workplace design features such as restricted access and security cameras have been advocated (May & Grubbs, 2002).

Lack of action by management is consistently reported in the literature as a reason for the under-reporting of episodes of patient-related violence in all clinical settings (Gallant-Roman, 2008). Nurses should be encouraged to report all violent incidents so that an accurate picture of the problem can be created to guide policy development in this area (Lyneham, 2000).

Training is frequently claimed to be an effective management tool in combating workplace violence, and is mandatory in New South Wales (NSW Health, 2005). However nurses are still not adequately trained (Lyneham, 2000). The nature of triage nursing means that the nurses' communication skills and coping mechanisms are vital for the prevention and de-escalation of violence (Jones & Lyneham, 2000).

Conclusion

It is evident that patient-related violence at triage is a reality for ED nurses in their everyday working lives; however this is an unacceptable hazard in their workplace. A major issue appears to be the lack of commitment on the part of employers: firstly to acknowledge the magnitude and seriousness of the issue and secondly to adopt preventive and supportive strategies to manage it. While patient-related violence may not be totally eliminated in the ED, it can be reduced so that ED nurses are working in a safer working environment as mandated under Occupational Health and Safety legislation (Pich et al, 2010).

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Educational goals
1. To gain an Australian perspective on a global issue facing nurses, that of patient-related workplace violence.
2. To be able to recognise some of the common precipitating and causal factors of episodes of patient-related violence identified in this study that are consistent with literature.

Correspondence

Mrs Jacqueline Pich
University of Newcastle - School of Nursing & Midwifery
University Drive
2301
Callaghan, Newcastle
Australia
+61 249 215 768
Jacqueline.Pich@newcastle.edu.au

Prevention and management of violence (AVEKKI) in Health Care Study Programme at Savonia University of Applied Sciences

Poster

Seija Taattola, Anna-Leena Ruotsalainen
Savonia University of Applied Sciences, Kuopio, Finland

Project Background and Objectives:

Savonia University of Applied Sciences, Health Care Unit in Kuopio had a development project (2005 - 2007) with working life in which a practice model for prevention and management of violence was developed. The goal was to develop a uniform training and approach model for facing patients' / clients' violence and challenging behavior. Furthermore, the goals were occupational safety, occupational health maintenance and promotion, the improvement of service quality received by the patients / clients, expansion of regional know-how and deepening in education and working life.

The AVEKKI practice model

The AVEKKI-practice model emphasizes the professional, appreciative and respectful confrontation of the clients while taking into account self-determination and customer orientation. From the workplace's point of view, zero tolerance and community based health care are emphasized, such as a common understanding of facing the violent patient / client and dealing with the situation. AVEKKI-model approach is a process which proceeds from prevention, through various levels of management to the post-settlement. In physical control the main goals are painlessness and safety.

The application of the model to education and working life

In the study programme of Health Care at Savonia University of Applied Sciences in Kuopio, there is a 1 credit course in the curriculum about prevention and management of violence. The aim of the studies is to give the right skills for health care students to face situations with challenging patients. The studies include a theoretical part which includes, for example Finnish legislation against violent encounters with a patient, principles and classifications of prevention and management in violence situations, as well as professional and unprofessional behavior, a principle of controlled limitation and communication. Theoretical study is carried out through e-learning. In addition, there is practical training for self-protection and the patient's physical control, such as the patient's verbal confrontation and appeasement and limitation in seated position, on the floor and in bed.

Savonia University of Applied Sciences in Health Care Kuopio has trained workers to work as an AVEKKI instructor. They educate employees in their workplace how to prevent and manage violence. In this way the same approach spreads to the whole work unit. With this policy it becomes possible to take into account specific features of the work community and development and harmonization of work practices. Workplace trainers maintain workers' knowhow by organizing regular maintenance or further training.

Today AVEKKI-approach is widely used in social and health care in Eastern Finland. In addition, Savonia University of Applied Sciences in Health Care Kuopio has started an AVEKKI Competence Center, the task of which is to organize education nationwide, to further develop the model and activate research. The AVEKKI instructors in Finland are currently from 120 different sectors (social and health care, education, tourism, catering and domestic services and hospital security). Trainers' skills will be monitored by the AVEKKI- Competence Center.

Educational goals
1. Practical Training model against violance and aggressive patient behavior.
2. We give information about this model and how we use it in Savonia University of Applied Sciences in Health Care Kuopio.

Correspondence

Mrs Seija Taattola
Savonia University of Applied Sciences
PL 1028
70111
Kuopio
Finland
+35 8 17 255 6000
seija.taattola@savonia.fi

Patterns in use of seclusion, restraints and involuntary medication in acute psychiatric wards in Norway

Poster

Tonje Lossius Husum, Johan Håkon Bjørngaard, Arnstein Finset, Toreif Ruud
SINTEF Research Institute, Oslo, Norway

Background

When coercion is used both patient and staff can be injured. Use of coercion in treatment may also threaten the quality of care and patients human rights. Therefore it is of great importance to reduce the use of coercion in mental health care. To be able to reduce the use we need to understand the factors involvement in the process which coercion are used. Previous research on mental health care has shown considerable differences in use of seclusion, restraint and involuntary medication among different wards and geographical areas. This study investigates to what extent use of seclusion, restraint and involuntary medication for involuntary admitted patients in Norwegian acute psychiatric wards is associated with patient, staff and ward characteristics. The study includes data from 32 acute psychiatric wards.

Method

Multilevel logistic regression using Stata was applied with data from 1016 involuntary admitted patients that were linked to data about wards. The sample comprised two hierarchical levels (patients and wards) and the dependent variables had two values (0 = no use and 1 = use). Coercive measures were defined as use of seclusion, restraint and involuntary depot medication during hospitalization.

Results

Data from 1016 patients could be linked in the multilevel analysis. There was a substantial between-ward variance in the use of coercive measures; however, this was influenced to some extent by compositional differences across wards, especially for the use of restraint. The total number of involuntary admitted patients was 1214 (35% of total sample). The percentage of patients who were exposed to coercive measures ranged from 0–88% across wards. Of the involuntary admitted patients, 424 (35%) had been secluded, 117 (10%) had been restrained and 113 (9%) had received involuntary depot medication at discharge. Client aggression measured using HoNOS was a main reason for use of seclusion and restraints.

Conclusions

The substantial between-ward variance, even when adjusting for patients' individual psychopathology, indicates that ward factors influence the use of seclusion, restraint and involuntary medication and that some wards have the potential for quality improvement. Hence, interventions to reduce the use of seclusion, restraint and involuntary medication should take into account organizational and environmental factors. Reasons for conflicts between staff and patients should also be investigated as interventions to facilitate better and non-violent interaction between staff and patients. Staff training should be targeted to train staff in de-escalation techniques and to be able to better communicate with patients.

Educational goals
1. Interventions to reduce the use of seclusion, restraint and involuntary medication should take into account organizational and environmental factors.
2. Reasons for conflicts between staff and patients should be investigated as interventions to facilitate better and non-violent interaction between staff and patients.

Correspondence

Mrs Tonje Lossius Husum
SINTEF Research Institute
Postboks 124
0314
Oslo
Norway
+47 41280305
tonje.l.husum@sintef.no

Violence against health professionals in Palestinian Hospitals: Prevalence and prevention

Paper

Naji Abu Ali
Makassed Hospital, Bethlehem University, Jerusalem, Palestine

Abstract

Violence and assault in the health sector are recognized as significant occupational hazards for health professionals. However, all health care providers are in danger of violence and assault from patients, family members or visitors. Moreover, nurses are more susceptible to violence as they spent most of the time with patient and his/her families. As violence increases in society, the risks facing health professionals increase. Also, violence has become the second cause of death in societies like the U.S.A. (Mayer et al 1999). It is important for health care provider to realise that violence and aggression from patients results from a number of variables like stress, pain, fear of the unknown, extended waiting time to be seen and treated, adequacy of staffing, lack of visible security and noxious stimuli like the sound of monitors (Presly, 2002). There are also environmental causes for example an unpleasant waiting environment, uncomfortable and insufficient seating, and lack of distraction, T.V., magazines, telephones and posters. All of these aspects can lead to violence.

A quantitative approach was adopted to investigate the prevalence of violence in health care settings and measures used by staff to prevent such violence. Cross-sectional non-experimental description design was used. -probability sample (Stratified clustered) of health care provider working in Palestinian hospitals located within an area of 80 km square were selected. An instrument developed by the International Council of Nurses (ICN) was used to collect the data. Sample size was 134 nurse and physician. Descriptive statistic methods were used and the findings were statistically interpreted using the statistical package for Social Science (SPSS). Results show that the prevalence of verbal abuse was reported by the majority of the respondents100 (74.6) and 46(34.3) had experienced physical attack in the last 12 months. The main perpetrators of violence were relatives, followed by patients. Reporting of violent incidents by victims was low, as they think it is useless and not important, Support given to the victims was low and training in relation to violent behaviour was minimal.

Introduction

Violence and assault in the health sector are recognized as significant occupational hazards for health professionals. However, all health care providers are in danger of violence and assault from patients, family members or visitors. Moreover, nurses are more susceptible to violence as they spent most of the time with patient and his/her families. As violence increases in society, the risks facing health professionals increase. Many researches point out that the prevalence of violent behaviour has increased in recent years (Rippon 2000 and Robinson. 2002,ENA 1999, Brantley 1992, Aple & Hoag 1993, Mayer et al, 1999). A British study was carried out in 1995, based on a questionnaire survey with a sample of 300 randomly chosen nurses. The study identified that 33.3% experienced physical violence (Schneider & Harren-Bell 1995). Also, violence has become the second cause of death in societies like the U.S.A. (Mayer et al 1999). The true incidence of violence in the health care setting is difficult to estimate due to different definitions of workplace violence, different data collection systems and significance. In the United Kingdom, health care workers have a three to four fold higher risk of workplace of violence than other workers (Health and Safety Executive, 1999). An other quantitative study by Erickson & Williams (2000) revealed that 82% of nurses surveyed had been assaulted during their careers. Moreover, it is important for health care provider to realise that violence and aggression from patients results from a number of variables like stress, pain, fear of the unknown, extended waiting time to be seen and treated, adequacy of staffing, lack of visible security and noxious stimuli like the sound of monitors (Presly, 2002). There are also environmental causes for example an unpleasant waiting environment, uncomfortable and insufficient seating, and lack of distraction, T.V., magazines, telephones and posters. All of these aspects can lead to violence.
Violence is a difficult term to define (Brennan, 2000). Dennen (1980) discovered 106 definitions of the term. In this study the ICN workplace violence definition is adopted and it is defined as: "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" (ICN, 2003. page 2).

In the last 10 years, there has been more concern about violence prevention than previously. Action must be taken by the health care industry, along governmental agencies and violence experts (OSHA, 1998). Any prevention program requires strong commitment from health-care administration, and a clear written policy for job safety and security, which is communicated to all staff. The availability of adequate numbers of trained medical and staff personal prevents long waiting times and allow good communication and development of good patient-staff relationships; which minimize the violent incidents.

Study aim

The main purpose of the study is to investigate the prevalence of violence against health care providers in Palestinian hospitals and to identify the preventative measures used to prevent such violence.

Method

A non-experimental, cross-sectional, descriptive survey was used in this study to identify the prevalence of violence and to identify the preventative measures used to prevent aggression and violence against health care professionals in Palestine.

Sample and data collection

The sample includes 134 health care providers whom working in five hospitals located in an area of 80-square kms in Palestine. The hospitals were located in three different geographical areas: the Rafedia Governmental hospital and Ramalla Governmental Hospital represent the northern area, Makassed hospital represents the Jerusalem area, and Beit Jalla Governmental Hospital represents the middle area and finally Al Ahli hospital represents the southern area. Three of these hospitals are governmental public hospitals, tow are non-profit, non-governmental hospitals. The sampling process was clustered stratified sampling.

Results

The demographic characteristics of respondents showed that 6 (64.2%) were male, and 48 (35.8%) female. 79 (59%) respondents fall within the 20 – 30 age category. 96(71.6) are Nurses, 16(11.9) are specialist, and 17(12.7) are general practitioners(GP)as shown in table 1.

Table 1: Present job, experience, department and employment sectors of respondents

	Number	Percent (%)	System missing
Present Job			
Physician	16	11.9	
Resident Dr	17	12.7	
Nurse	96	71.6	-
Student	3	2.2	
Others	2	1.5	
Total	134	100	
Department			
Emergency Dept	39	29.1	
General ward	42	31.3	
Critical care Dept	33	24.6	
Geriatric ward	3	2.2	-
Paediatric Dept	10	7.5	
Gyn. & Obs. Dept	4	3	
Outpatients' clinics	3	2.2	
Total	134	100	
Years of work			
Less than 5 years	68	50.7	2
5 – 10 years	32	23.9	
11 – 15 years	18	13.4	
More than 16 years	14	10.4	
Total	132	98.5	1.5

The prevalence of physical and verbal abuse is presented in Figure 1. The results show that 46(34.3%) of respondents have been physically attacked while 100(74.6%) of them have been verbally abused. Moreover, the majority of attacker was the relatives followed by patients.

Figure 1: The prevalence of physical and verbal abuse
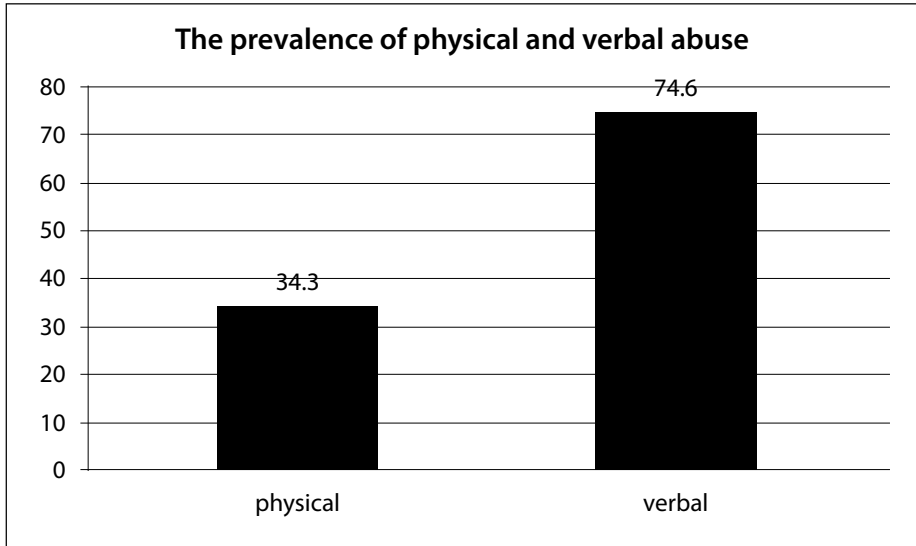
The majority of victims took a combination of measures in response to the violence experienced. In case of both physical and verbal violence the majority of victims told the person to stop, told family or friend, took no action, and pretended that the incident never happened or reported to senior staff.

The descriptions of all the existing measures that may minimize violence in the workplace, as reported by all respondents includes security measures, improved surroundings, restricted exchange of money, patient screening and reduced periods of working alone are the most frequent measures taken to deal with violence.

The employer did take action in response to violence incidents. Results shows that action was taken only to one third of the incidents for both physical and verbal abuse as reported by the victims, while around two third of respondents said there was no action taken by the employer. In relation to the consequences to the perpetrator, around one third of cases issued verbal warning and only one fifth reported to the police, while 41% of perpetrators ha no action taken. Around 25 percent of victims reported that incidents could be prevented in cases of physical violence while around 40% for verbal abuse.

Discussion and Conclusion

The prevalence of physical violence was measured in this study, finding that 34.1% of the respondents experienced physical violence at their workplace during the last 12 months. This is much higher than the rate Deep found (5.8%) or that found by Atwaneh et al. (16%) in general hospital in Kuwait. This is in spite the fact that all these studies were done in areas of similar cultural background and geographic zone. However, the rate found by this research falls within the standard range of similar studies. Schneider & Marren-Bell's (1995) study registered 33.3% of randomly chosen nurses exposed to physical violence, of whom 35% were from emergency department nursing staff. Also Rippon (2000) found 30% of hospital staff, Mayer (1999) 41.5% of emergency department nurses, Rose (1997) 40% of nurses and care assistants working in Ireland's largest Dublin hospital and Steinman (2003) 27% of respondents had all been exposed to violence. On the other hand this rate is much lower than the rate reported by Gannon, which reached 85.1% of the sample experiencing physical abuse. This difference could be related to the fact that Gannon's study was done in dementia wards where the patients were suffering from severe uncontrolled conditions.

The frustration-aggression hypothesis of Dollard et al. (1939) could explain why the prevalence of violence in this study is higher than in similar studies done in similar geographic areas such as the Deep and Atwaneh et al. studies. As mentioned above, Palestinians face a huge amount of difficulty throughout their daily life which increases the frustration which precedes aggression. This cause of violence is different from that of either study. For example - Mayer's - who found that there is a significant correlation (1-tailed Pearson, p = 0.001) existing between incidents during the past year and the number of perpetrators perceived to be under the influence of alcohol. No gender difference was found in rates of abuse but it was higher across employee grades and years of experience in healthcare. Most of the respondents were working full –time and in shifts. Contrary to the other studies the rates of abuse are much higher during day shifts. Relatives were the main perpetrators in this study, contrary to other studies where the clients or patients were the main perpetrators. The type of health sector is seen to be one of the factors that affect the prevalence of assaults. Workers in public and non-profit health sectors are exposed to physical and verbal abuse much more than in private health sectors.

Consistent with other studies, the rate of reporting of incidents was low and limited at the senior level. The reason for the low reporting level seemed to be related to the low response rate of actions that were taken by the employers themselves. The respondents showed a low degree of satisfaction with the way the incidents were handled. The Nursing Union was seen as having an unproductive effect and function on the management of violence and assaults that occurred at the health workplace.

Respondents believed that improving the surroundings and the measures that deal with patient issues are the most effective factors in controlling and decreasing the extent of violence. Respondents showed a low level of awareness of policies and the procedures which deal with the reporting of violence. However, the higher ranks of staff were more aware of these polices and procedures. In spite of the fact that the respondents showed positive attitudes toward the efficiency of formal education training programmes in dealing with violent behaviour, the level of provision of these programmes at their health institutions was low.

Unfortunately, working within the existing situation caused unhealthy feeling for the respondents of this study. Worry and uneasiness were wide spread and intensified by the feeling of being unsupported that the respondents experienced after the violent incidents. All these factors play a part in the development of the carelessness in relation to formal reporting of incidents.

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Educational goals
1. Violence against health care provider increase and the staff should have the skills and knowledge on how to prevent, detect violent behaviour.
2. Commitment from management should be available to support and protect staff.

Correpondence

Mr Naji Abu Ali
Makassed Hospital
Bethlehem University
Jerusalim
Palestine
+972 2 627 02 22
najia@bethlehem.edu

Violence as management issue in old-age and nursing homes: Findings from Upper Austria

Paper

Rainer Loidl, Natascha Strutzenberger
University of Applied Sciences FH JOANNEUM, Graz, Austria

Introduction

Which dimension has the violence issue in old-age and nursing homes? Which role has the institutional context on tackling violence? And how does a professional nursing service manage the violence agenda? From these initial questions we present the violence issue from the perspective of nursing service management (NSM) based on the work of Strutzenberger (2007). Our investigation covers the old-age and nursing homes in Upper Austria (federal province of Austria) and their NSM (N=116; n=65). The study is inspired from organization sociology and shows, that violence in nursing homes is still somewhat like a "hot potato", but is chipping off being a "hidden agenda". However, the understandings of violence vary widely, in particular due to the circumstance that violence appears in combination with other conditions older people encounter: dementia, mental disease etc. Taking clear positions and making distinctions as well in order to manage violence intentionally remain unsolved from an organizational and professional view. A professional nursing service management is supposed to structurally integrate violence management.

Old-age and nursing homes in an institutional sociologist's view

Old-age and nursing homes are not only facilities in which persons of higher age are cared for and looked after with different care neediness. In a sociological view they are also institutions with specific rules, expectations, norms, interests, relations etc. In this institutional context problems can appear and arise or older people bring in at nursing home admission. Institutional rules and its specific problematic issues must be picked out and people – staff, residents, relatives and other institutional members as well – involved should be aware of the institutional dimension and its consequences for everyday life and work.

In the everyday language the concept "institution" is synonymously used for "service" [in the German language countries] often. Institutions are marked by special characteristics and understood as school, hospital, church, governmental agency or civil service, as old-age and nursing home. The concept of "institution" looks back on a long tradition not only in sociology. Very briefly spoken, institutions are defined "as an organized, established procedure" (Jepperson in Powell & DiMaggio, p. 143). The definition of other sociologists also directs on the meaning of regulation: Institutions are relatively stable and obligatory action models (`Regelsysteme´) shared by a group of protagonists. Institutions make specific, although situation-independent behavior possible and create both possibilities and restrictions in its interaction contexts (Müller-Jentsch in Schmid & Maurer, p. 245). Building up on these definitions the rules of the home, the home and care contracts and the legal home regulations (they are different in the Austrian federal provinces) are elements of the institution, which make actions possible or restrict these for all protagonists, i.e. home administration, care management, nursing staff, other employees and also the home residents and their family members. Institutions regulate a certain "action modus" and become shared control systems.

Through this the old-age and nursing home becomes an institution which is surrounded by different sets of rules. These sets of rules which must be handled by the protagonists, in this case by the NSM, have an important role. Of course it also can come to conflict events or to violent acts. The institutionalization – the process of institution emergence – is seen coming from to forces: on the one hand, laws, statutes, acts etc. regulate actions and represent a collective norm; on the other hand, routine and habits can be so decisive, that it becomes an institution (Hasse & Krücken, p. 55).

In regard to old-age and nursing homes both possibilities are conceivable. However, the laws which are enacted in this area make a crucial contribution to the institutionalization of the geriatric care and support, for certain, from the nursing laws up to the home ordinances and the "Heimaufenthaltsgesetz" ("home residence law"). By this way of the institutionalization it also comes to a stronger formalization here, e.g. what can be seen in the area of the documentation duty.

The concept "total institution" was marked by Goffman and also covers old-age and nursing homes; after his definition they are dependent and regarded as harmless (Goffman, p. 16). We follow Goffman's argument, because, although the homes represent a total institution, they might be seen as "harmless" in comparison with other "total" institutions, e.g. a prison. And we argue that a hospital may show a more total institution characteristic as an old-age and nursing home. Goffman describes the total institutions as life and work places in which a variety of similar individuals is insulated "outside" of the society for a longer period. In consequence this leads to a isolated, regularized formally life (Goffman, p. 11). For the residents of old-age and nursing homes this "longer time period" describes the time between the home admission and the death in most cases. In connection with this, the fact that the home always concerns the last phase of one's life, too, may not be forgotten. Too often the residence in an old-age and nursing home represents the stage of the "terminal of the life", and many people concerned are not able to deal with this circumstance in an appropriate way.

Anthes also refers to Goffman in explanations of the total institution. In this view, the institution can cause conflicts between nursing staff and old people. Old-age und nursing homes are characterized by the circumstance, that life is getting limited and that their exist a fundamental distinction between the life in the own "four walls" at home and that one in an organized service (Anthes, in Knobling, p. 78). Another point is brought in by Gielen (p. 30), who describes the enormous potential of impact, burden and stress caused by the institution of old-age and nursing homes. The institution determines the whole life or residents, the service demands result in stress and pressure and many actions become schematical routine. This points to the correspondences of institutional and organizational conditions, organizational procedures and potential problems. For example, due to structural stress causes and time restrictions on personnel an old person may feel uncomfortable and not perceived, which may cause impacts on well-being, stress, aggression level and violent action potential on the resident's side very likely.

The nursing service management in Austria

In Upper Austria – and the other Austrian federal provinces as well – nursing service management (NSM) is compulsory by law. NSM takes over an essential function and is ascribed to the middle management usually. It is responsible for internal control of care and nursing processes, preparation and supervision of the duty rota, control of the documentation, work with relatives, communication with external facilities and institutions (e.g. hospital), cooperation with doctors, very regularly for tasks concerned with staff policy (e.g. personnel planning, contact person for the staff) and initial consultation of interested parties. Over the last years it has to be observed in Austria that nursing home management education, or more general spoken, the management education of care and nursing professions becomes more academic and gets more integrated into the higher education system and universities, e.g. studies in care sciences, degrees in care service management on bachelor or MBA-level. It is obvious, that the middle management position and the organizational tasks of NSM comprehends tackling violence. Indeed, overlooking the management education we see that the curricula lack a strong "conflict and violence resolution" topic regularly.

Sources of frustration – Issues of violence in old-age and nursing homes

Forms of violence in old-age and nursing homes and it's causes are diverse and complex (Meyer, p. 141). Violence – in this context – can start out from different sides. From old people, relatives, care persons. Violence and aggression can appear or be aroused by different frustrations or as a part of a syndrome (e.g. dementia). The nursing staff can experience frustration by the old person and reversed. Structural framework conditions, the home admission, private problems cannot be forgotten on side of the old person and on side the caring (Meyer, p. 70). Violence can come from both emotional and physical causes. Violence in caring relations can go out from different groups and take different forms: the daughter deals violently with her mother in need of care, the old man with dementia hits out every time he gets cared, the old lady regularly attacks her room neighbour with the walking stick, the nurse hangs the bell higher deliberately so the resident could not reach the bell, etc. . Violent acting can take subtle forms. Violence – in case of old-age and nursing homes – results from structural frustration, e.g. time pressure, manpower shortage, education lacks, which leads to violent action within and outside the care relations if not tackled structurally.

Often, the care activity in old-age and nursing homes is perceived as endless care and the care success is the slowdown in the impairment (Ruthmann, in Meyer, p. 71). The nursing staff is confronted with sorrow and dying and therefore always with the infirmity of its own, too. Ingratitude and criticism must be accepted by the staff. Grumble, permanent ringing and, over all and principally, unrealizable claims lead to the feeling of being overstrained permanently. An transference aroused by the older person also can lead to the load of the nursing staff – e.g. the caring person feels reminded of an earlier, negative experienced authority

person by character traits of the older person. In consequence, negative feelings and antipathies can arise (Meyer, p. 70).

Another argument is brought in by Dießenbacher & Schüller (p. 17), who characterize caring of older people as potentially depressing. They describe caring of older people having similarities to that one of babies. But, missing the "Kindchenschema" no care instinct is activated – caring people look into an old man's face, which may cause fear against the ageing of oneself and attack the reflection of the short getting future of oneself. The nursing staff can the other way round arouse frustrations for the older also. Too often, the old person gets little attention or talking possibilities – certainly, he is cared for physically, due to lack of personnel and/or time private conversation, however, drops out. In addition, frustration emerges if intimacy and privacy is not protected and broken, e.g. not knocking at the room door (Meyer, p. 77).

According to Bojack (p. 65) various causes exist why older people act violently, one main reason lies in own experiences: violent practices were endured and/or watched in childhood, former abuse experiences turn up again. Experiences and memories long restrained come back, formerly applied strategies do not work anymore.

Helplessness and palsy follow and lead to violent behaviour: violence appears when people lose learnt control mechanisms and power about themselves. Need of care and power loss concur. One may hardly bear this situation. When older – and people in general – encounter helplessness and palsy they may not accept and therefore to try to cover it up by aggressive or violent behaviour. And in particular, in combination with illnesses in older life, dementia or Alzheimer alike, people lose rational control or strategic behaviour and get more affective.

Outside the nursing and caring relation it can come to frustrations by structural compulsions and individual factors, both on the part of the staff and on the side of the old people, which can have an effect again on the nursing relation in a broader consequence (Meyer, p.80). For example, inadequate working time management/systems cause irritations. Irregular working times, the workload and the staff or lack of time seems to be the crucial structural problems the nursing staff faces. Or frustrations come from team relations and working conflicts (e.g. handing over services and documentation, mobbing, unequal allocated working traits/benefits/disadvantages).

Among the persons in need of care the home admission, the increasing dependence and the ageing can lead to frustrations to themselves. The structural compulsions also influence the resident, the individual life design is adapted to the framework conditions of the institution, one must as well orientate himself at the predefined day structuring. Other sources of frustration lay in the personal daily observation of physical changes of other residents and in the steadily decrease of social contacts (Meyer, p. 90). According to Knobling (p. 87), who questioned elderly in old-age and nursing homes, for them specific situation-related conflict loaded and frustration potentials exist in their dependence on the staff with carrying out their nature´s call or other situations as well, like dressing, having meal or pain relief.

The violence issue in the nursing service management perspective – Empirical evidence from an Upper Austrian study

The survey of Upper Austrian "Pflegedienstleitungen" (Nursing service managers – NSM) is a full investigation of all old-age and nursing homes in Upper Austria, at the time of the year 2007 the number was 116. In the individual telephone-interviews (Bortz & Döring, p. 239) 65 nursing service managers took part, covering 66 homes (one manager was in duty for two homes). The response rate is 56.9%. Three open ex-ante interviews were conducted in order to collect the structuring questions for the partly standardized and fully structured questionnaire (Kromrey, p. 389; Rieder, p. 46).

The examination, part in the work of Strutzenberger (2007), is based on the following question: How do problem situations appear in Upper Austrian old-age and nursing homes from the point of view of NSM? The question is theory conducted strongly since an intensive literature work presupposes, out of that four problem areas were identified. Besides violence problematic areas for the daily work of nursing home management are alcohol dependence, psychopharmacological drugs/ demand medication and mental illnesses.

What do the results show? Violent emotional or physical assaults happen according to 84.6% of the NSM (if not stated otherwise we refer to n=65), of which three quarter (67.3%) report that violent action would come from the residents. In their experience violence coming from residents occur to a large part (38.2%) from persons who suffer from dementia or Alzheimer or another mental disease. A smaller part (9.1%) relates violent action to alcoholism of residents. Only a few NSM (5.5%) refer to violence coming from

nursing staff, in these few cases described as aggressive verbal attacks of personnel on residents mostly. Job dismissal because of violent acting personnel is reporting in single cases only (1.8%).

Regarding the frequency 41.8% of the NSM (n = 55) say that violence appears seldom – in single cases, once or twice a year –, 23.6% quote sometimes – each month, sometimes or even more times a year – and at least another 34.5% often – that means a couple of times a month, weekly, daily. To a high degree the NSM say (81.3%) the topic violence and aggression is discussed at least, 28.8% contact a doctor. A more intensive management in terms of case management or biographically-oriented client work is partly realized only (28.8%). Very interestingly, only 22.0% of the NSM think it is important to structurally support the staff with education, seminars, coaching, supervision etc. in order to tackle violence – the nursing staff seems to be quite alone and the violence issue is left behind in management. Finding concrete solutions of a violent act and situation is important for only 15.3%. Instead, some (10.2%) address the violence act by distracting the older person concerned through give him/her an activity to calm down. Another strategy for some NSM (10.2%) is to take the violent acting person out from the group in order to protect others. Other strategies for tackling violence acts and situations are: accommodation of the person in a psychiatric hospital (8.5%), particularly in case the violent act gets more heavily; another, a new medication (8.5%); cooperation with the resident's relatives (6.8%); a change of the nursing person in charge (6.8%) arguing with "the better personal connection" of the other nursing person to the resident concerned with violence. Out of the view of a small part of the NSM only (5.1%) the violence act/situation should be documented precisely and accurate. Cooperation with other institutions and public relations is somewhat of a side-stage (1.7%). The same counts to the cooperation with police (1.7%) in more powerful violence situations – it seems to be a blind spot.

When it comes to the question of sanctions in practice we find a similar situation. For most NSM sanctions are definitely conceivable and also are applied (67.7%), if it comes to solid problems following violence. 36.4% (for this and the following n=44) of the NSM indicate an accommodation in a psychiatry as a sanction. Other ways of setting sanctions on violence are cancellation of homing contract (20.5%), contacting a doctor (20.5%), medication (15.9%), meetings and consulting with all persons concerned (15.9%), replacement of the resident in another home (18.2%), cooperation with police (11.4%) or to demonstrate the possibilities and limitations to the resident and state out a warning (11.4%). Only a 2.3% say that the violent act would be documented and find its way into the resident's file. 26.2% of the management states out that no sanctions or consequences on violence are set from the organization or management.

Which consequences of violence do NSM observe on other residents? What happens do the social living context? Primarily, violent acting of one causes fair and uncertainty to other residents (57.9%; for this and the following n=65). In a part of cases violence infects other residents getting more aggressive and violent themselves (15.8%) or makes them feel annoyed and agitated (12.3%). A social exclusion of the violent person from the group of residents is found some times (7.0%), so is seeking help from the nursing staff (3.5%) or being ashamed for the violent acting person (3.5%). Mutual calming is observed seldom (1.8%), and also only in few cases people feel reminded of their own violent childhood or experiences (1.8%).

The survey and the open interviews indicate an almost even part of men and women showing violent behaviour. If we take into account, that the population of residents consists in a higher part of women than men, in general, not very surprisingly among other statistics the percentage of male aggressors seems to be higher. Interestingly, the NSM tell about gender-specific violence forms. So, women rather tend to verbal violence, whereas men act more aggressive and tend to physical violence. Male violence is seen to be potentially more "dangerous" than female one. In contrast, violence of women seems to be more accepted as part of their disease. For further research different attribution styles of male and female forms of violence would be of high interest.

Standards or formal guidelines to tackle with violence in old-age and nursing homes are not available to a large part (86.2%).

Conclusion

Violence in caring relations and in old-age and nursing homes is an issue: more than 80 percent of the questioned nursing home managers reports of violent occurrences. In contrast, management strategies in dealing with violence are practiced only partly. Violence plays a role in combination with mental diseases as dementia, Alzheimer or alike. Tackling with violence intentionally or, moreover, the professional management is still a future picture to be reached out for. The attitudes to and against violence vary. For one the over-caring presents a form of violence already, for another it is still not seen as violent act when a person suffering from dementia hits another one. Perhaps one interview passage brings it to the crucial

point: "because, well, often caring and nursing itself is violence already" (interview). The institution old-age and nursing home remains being an undesirable and unwanted context. The residence is no free choice, it is forced compliance. It presents a potentially violent act itself, scratching ones integrity. We argue that institutionalization on the way to a "total institution" means isolation, and the higher an isolation degree is the higher a violence risk gets. In dealing with violence it gets important to create institutional regulations for bridging the institutions.

However, in the investigated context frustration, aggression and violence often appear in correspondence and/or due to an illness, e.g. Alzheimer or dementia. The most problematic difficulties are the question on: What is violence then between "not yet" and "already"? When does it start, when end? Actually, the problem on the ground is about accountability. We observe one and the same action, e.g. a kick from one on another person. In one case it is performed by an old man with dementia, in another by a five-year old child, in another case by a person with mental disabilities, again in another case by an ordinary man. One can assume that violence has different causes and expresses in a variety of forms, in caring contexts too, and even given a same level of consciousness of/against violent acts it seems that we take the situational context – different situations and violence performing persons – into account. That might be an essential element for a problematic and diverse understanding and definition of violence, but it is neither a reason for being unaware nor for exclude the violence issue from nursing service management.

All the more, questioning, investigating and managing the violence issue gets more important. The institutional context comprises frustrating conditions which potentially promote conflicts and violence, and in comparison people may have less acting possibilities at their command than in some other institutions. However, the violence issue is never taken into consideration in correspondence with structural and institutional conditions.

One answer is to implement regulations. The rationale of NSM against standards or regulations is reasoning that the specific needs in a concrete situation and of the person concerned would require and only allow individual care reactions. That attitude stands in opposite to a profound understanding of the organizational context: of course, each has to act and react in a certain situation, but standardization differs from ignorance. And it means to have strategies in mind for getting supported as well. Burn-out emerge from organizational and management deficits in many cases. It seems that the issue of tackling with violence is highly individualized. We found only little evidence that nursing service management would recognize standards and structural-organizational arrangements as helpful or supportive. The lack of regulation or guidelines in dealing with the violence results in uncertainties, vagueness, or ambiguities. Residents, relatives and staff as well have to solve the situations individually – are left alone actually. Clarifying the management of violence is supposed to increase certainty for all people involved.

The management tasks in tackling violence are manifold, from protection to supporting to reporting to cooperation. The management repertoire of NSM could consist in: increasing awareness, identify and dealing with violence in all its, even subtle, forms; making strategies available, e.g. action regulation and standards; consult professional organizations for violence management (e.g. "Gewaltschutzzentren", i.e. victim and violence protection) and cooperate with internal and external professionals and relatives concerned; integration of violence into coaching, supervision and training (e.g. dealing with violent residents with dementia, strategies for conflict resolution and de-escalation); awareness building; explicit integration into documentation and management information systems; case management and social work; and others.

Only a few organizations have developed management guidelines for violence situation. Regularly, consulting people and organizations are then pressed into the "fire-worker-position". On the old-age and nursing home side – in the best case – a minor preparation exist, not more. In practice, violence becomes a "hot potato", it seems people in charge frame violence situation as still "single events" only. Of course, violence is an in fact unwanted event. But the understanding of violence as simply existing issue would offer and open new perspectives and strategies. We would argue that all parties are interested in clear regulations, which requires the awareness and a clear position against all forms of violence.

As other issues, violence in caring relations, here discussed in the context of old-age and nursing homes – the huge area of violence in caring at home is untouched in this consideration – refers to a societal and political dimension. Violence issues in caring relations need a broader political as well professional arena and resonance in order to point the spot on the circumstances described in this article and to change the insufficiencies structurally.

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One interview source used: IV_01_200307, p.15, line 475-476

Educational goals
1. To explore 'residents´ violence forms and patterns in old-age and nursing homes' on the basis of quantitative data from a representative study.
2. To present implications for service management and training.

Correspondence

Mr Rainer Loidl
University of Applied Sciences FH JOANNEUM
Eggenberger Allee 11
8020
Graz
Austria
+43 316 5453 8716
rainer.loidl@fh-joanneum.at

Reporting, cause attribution, and perceptions of workplace violence: a survey of healthcare staff

Paper

Catherine Trask, Vicky Mak, Andrea Lam, Chris Back
OHSAH - Occupational Health and Safety Agency for Healthcare, Vancouver, Canada

Introduction

Violence is a prevalent occupational hazard in the healthcare sector worldwide [1, 2] which affects healthcare workers across multiple care settings [3]. In the Canadian province of British Columbia (BC), the healthcare industry has the highest incidence of violence compared with other industries; healthcare workers represent approximately 10% of the provincial workforce, yet 55% of all violence-related claims were accepted from healthcare workers [4].

Despite the ample documentation of violence experienced by healthcare workers and its health effects, the true scope of the problem is under-represented as over half of all violent incidents may go unreported [5]. This could be because workers believe that reporting will not benefit them in addressing or dealing with the issue, or they fear that their employers or colleagues consider violent acts to be the result of the employee's negligence, or poor job performance [1]. Most often, violence is perceived to be normal and is accepted as part of a healthcare job, or the act committed by the perpetrator is perceived to be unintentional, and therefore is not worth reporting [6]. If violence prevention polices and procedures are perceived to be ineffective, workers may also believe that reporting will not benefit them in addressing or dealing with the issue. The objectives of this project were to examine the relationships between reporting experience, attribution, and perceptions of violence prevention program efficacy.

Methods

This project was conducted by a bipartite Provincial Violence Prevention Steering Committee (PVPSC), established through joint collaboration of BC's healthcare stakeholders. The PVPSC's mission is to develop and oversee implementation of a comprehensive, cohesive and effective provincial violence prevention strategy for healthcare worksites in BC. The survey questions were developed based partly on literature review and partly through consultation with the PVPSC. The heavy workload and time pressures of healthcare workers were taken into account by limiting the number of survey questions (i.e., it would take less than 15 minutes to complete the survey). Survey questions were divided into the following categories:

1. Tolerance or acceptance of violence and reporting of violent incidents (verbally and in writing);
2. Personal experience and third-person experience (i.e., the experience of colleagues) with incidents of violence;
3. Perception of contributors of violent behaviours;
4. Perception of prevention efforts within the organization (safety at work, support of supervisor and colleagues, workplace procedures to protect workers, training, respondents' preparedness to respond to/prevent violent behaviour); and
5. Demographic information (age, gender, union affiliation, employer type, care setting, and occupations).

Question categories 1, 3 and 4 were administered using a five-point visual analogue Likert scale to measure participant's agreement to a specific statement. All workers who were employed in the healthcare industry in BC during the survey implementation period were eligible to participate. As an incentive, participants were eligible for a prize draw to win one of four Apple iPods. Subjects were recruited using an open recruitment and snowball method: it was promoted to all eligible workers rather than a targeted sub-sample. The snowball aspect of promotion occurred when stakeholders and participating workers promoted the survey to their colleagues, thereby increasing the sample size. The survey was promoted in several formats, including newsletters, websites, e-mails, e-mail signatures, posters, and pay stubs. PVPSC members initiated the snowball recruitment by asking their constituents to forward survey communication messages and promote the survey. Some examples of stakeholder-driven promotions included forwarding email messages, promoting the survey at a worksite through a Joint Occupational Health and Safety Committee, and distributing paper copies of the survey at annual conventions of union members.

Data was collected from January 31, 2009 to March 31, 2009. Frequency analysis and cross-tabulations were performed to calculate responses of individual survey questions and determine responses by demographic variables, respectively. Chi-square tests investigated any significant relationships between demographic variables and survey questions. For chi-squared tests, Likert scale categories were collapsed into binary variables. 'Strongly disagree', 'disagree' and 'neutral' were combined into a 'disagree' category; whereas 'somewhat agree' and 'strongly agree' were combined into an 'agree' category. All analyses were performed in SPSS 14.0 (SPSS Inc., Chicago, Illinois).

Results

There were 2,545 respondents to the survey; 1,821 survey responses were web-based and 724 survey responses were paper-based. The total responses account for 2.2% of the BC healthcare worker population. The largest number of the respondents came from the acute care setting (38.4%).

The most common types of violence experienced by respondents were verbal rather than physical (Figure 1). Registered nurses, licensed practical nurses, and care aides reported having experienced violence more often than other occupation groups. Respondents in long term care tended to report having experienced more violent incidents, including witnessing more violence, when compared to other settings.

The biggest perceived contributors to violence were system-wide issues: patient illness, short-staffing, and delays in attending to patient needs (Figure 2). Given the continuing demographic shift, these challenges are likely to accelerate rather than abate, as more healthcare workers retire and the aging population's healthcare needs increase [7].

In terms of worker perception of workplace violence controls (Figure 3), "feeling supported by supervisor/ colleagues" was the most common positive response, representing an area of strength to build upon. This result was also unexpected given the substantial amount of literature reporting the widespread problem of horizontal violence and bullying among healthcare workers [8]. However, the next two most commonly agreed-with statements, "training on how to recognize, report, and react to behaviour" and "workplace has procedures in place to protect workers," only had the agreement of approximately half the respondents, which highlights some opportunities for employer-driven controls. Discouragingly, only about a third of workers agreed with statements that indicated feelings of security (i.e., "feeling protected by effective safety measures" and "feeling safe from violence").

Figure 1: Frequency of responses for respondents' personal and third-person experience with incidents of violence

Types of Violence

■ Yes, to me   □ Yes, to a co-worker
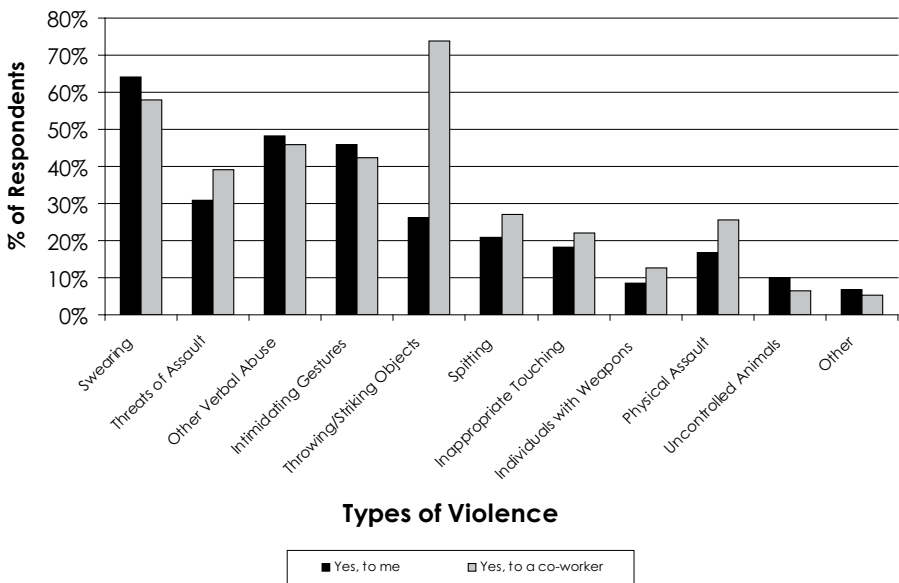
Figure 2: Frequency of 'agree' or 'strongly agree' responses for perceived contributing factors for violent behaviours
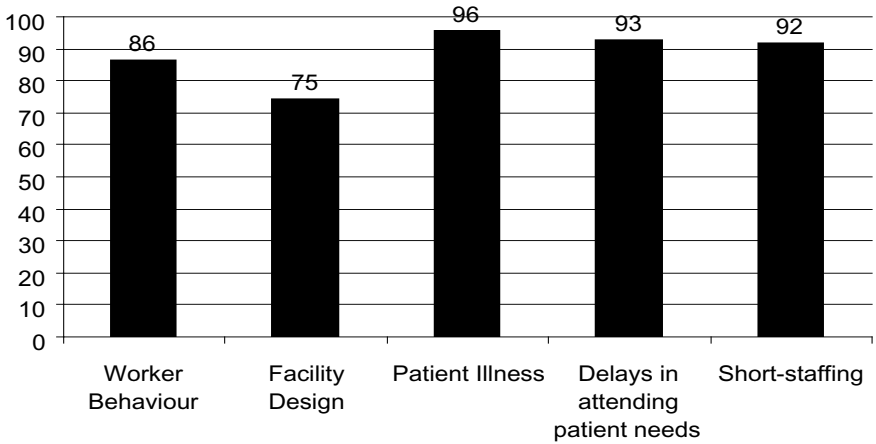
Figure 3: Frequency of 'agree' or 'strongly agree' responses for perceived effectiveness of prevention efforts within the organization
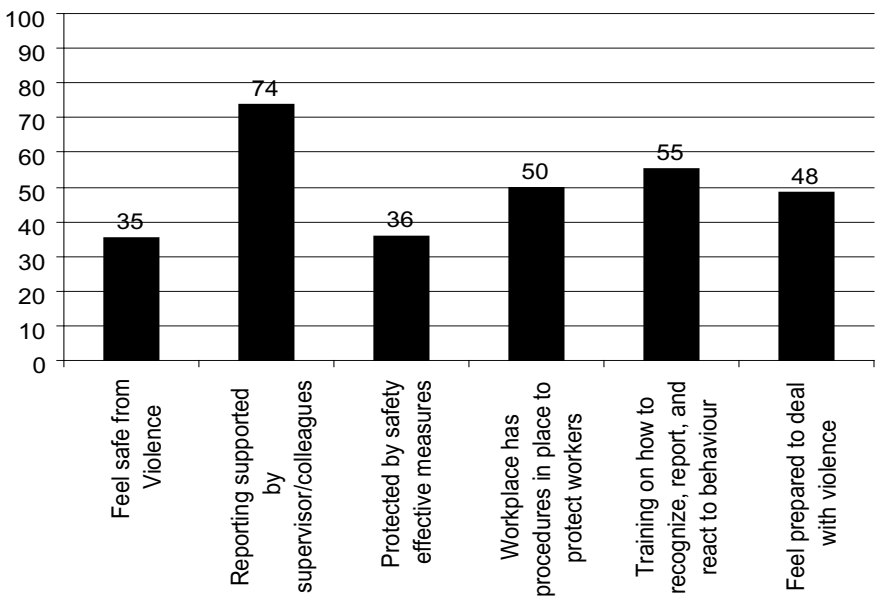
Conclusion

Among the identified gaps and needs are several systemic issues, such as patient acuity and short-staffing, that represent a persistent challenge to the BC healthcare industry. Although addressing such issues are beyond the scope of the PVPSC, the Committee will need to understand and consider them in order to successfully advocate for and coordinate occupational health and safety efforts with system-wide efforts to address the human resources crisis in healthcare. In terms of specific violence prevention interventions, the results suggest that there is a need to enhance a positive reporting culture (especially for verbal violence), starting with identifying barriers to reporting verbal violence (such as tolerance, frequency, desensitization, and time requirements) and developing interventions to eliminate barriers to reporting. Worker behaviour was seen as a contributor by almost half of respondents. This may highlight a need for more training in violence prevention techniques. However, this finding may also point to a need for increased recognition of other factors, such as patients' illness and behaviours and appropriate ways of addressing them. Enhanced training and procedures may raise the awareness of or increase the perceptions of safety among respondents, but will require a continued dialogue between management and front line workers about workplace violence risk factors, implementation of controls, and effectiveness of violence prevention programs.

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Educational goals
The objectives of sharing the results of the survey are threefold:
1. to assess reporting behaviours in relation to incidence of violence
2. to allow identification of priority areas for prevention efforts based on the types of violence encountered in different healthcare settings and departments
3. to inform the development of targeted, relevant violence prevention resources, including educational campaigns designed to enhance reporting culture

Correspondence

Mrs Catherine Trask
OHSAH - Occupational Health and Safety Agency for Healthcare
Suite 301 - 1195 W Broadway
V6H 3X5
Vancouver
Canada
+1 604 221 0553
cmtrask@gmail.com

Violence against community health nurses in Cape Town, South Africa

Seminar

Faizah Kajee-Adams, Doris Deedei Khalil
Faculty of Health Sciences, University of Cape Town, Cape Town, South Africa

Introduction

In 1992 the then minister of health declared that a policy of primary health care must be followed to make healthcare more available, accessible and affordable to all South Africans (Hatting, Dreyer & Roos 2004). At that time, community care clinics were understaffed with overworked nurses, a situation that still exist after eighteen years of the policy implementation. The White Paper on the Transformation of the Health System, adopted in 1997, devolved responsibilities for health care delivery to districts authorities, thus establishing District Health Systems which would be more responsive to needs of people at grassroots levels (De Haan 2005). Violence in community health clinics reflects historical events.

During the apartheid era in South Africa, violence was viewed as legitimate response to oppression. That oppression resulted in more than thirty years of violence, reaching peaks during the Sharpeville Massacre in 1960, the Soweto uprisings in 1976 and other uprisings in 1985 and 1986 (Baldwin-Ragaven et al, 1999). Violence became feature of social life in the country until the African National and the Communist political parties were unbanned. To explore the extent that violence affected health care workers, Steinman (2003), studying Greater Johannesburg Metropolitan region found that sixty three percent of respondents experienced some form of violence. Marais, Van der Spur and Rontsch (2002) survey of health professionals in Cape Town found that fifty percent of respondents had experienced some form of violence at work. Di Martino (2000) reported evidence of workplace violence internationally. Kingma (2001) and Di Martino (2000) indicated that nurses were three times more likely to experience violence than other professional groups. Other studies had shown evidence of violence against nurses (Armstrong 2002; Adib, AlShatti, Kamal, El-Gerges, and Al-Ragem 2002; Atawneh, Zahid, Al-Sahlawi, Shahid, and Al-Farrah 2003; Khalil 2009). Based on the above literature, objectives of the study were to examine extent and frequency of violence against nursing staff in community health clinics.

Methods

The research design was survey. Methods of data collection were distribution of confidential questionnaires (Brink 2002). Approval to conduct the study was granted by the University of Cape Town, Faculty of Health Human Ethics Committee and the Metropole Health Directorate. The study population consist of all nurses working in the community health clinics in Cape Town. Research participants were recruited from community health clinics of seven sub-districts in Cape Town Metropole area of the city, i.e. Tygerberg, Mitchells plain, Klipfontein, Southern, Eastern, Western, and Northern. A total of twelve clinics formed the research sites for the study and to protect identities of participating clinics, each clinic was given a unique number, e.g. T1 representing Tygerberg community health clinic number 1.

Results

Out of the eighty-six respondents, 61% had been working as nurses for over 16 years. Mitchells Plain, Southern and Klipfontein health clinics had the highest number of more experienced nurses. Eighty respondents (N=80; 94%) agreed that there is violence in nursing. Supporting written comments were:

"Yes, nurses' work under so much stress. Clients come to the clinic with personal problems and fight with the staff" (Clinic T2)

"In our facility we have endless abuses from clients and sometimes from the community outside." (Clinic K2)

Women were reported to be responsible for 81% of violence against nursing staff. Other perpetrators were gang members (60%), and patient relatives (59%). However, perpetrators varied among sub-districts, e.g. 100% of respondents from Western sub-district indicated that women, Klipfontein identified patient relatives (83%) whilst Tygerberg regarded gang members (73%) as the main perpetrators.

Results indicated that violent incidences occur on mainly on Mondays and Fridays of the week in all the participating clinics. However, Tygerberg (16 incidences) and Klipfontein (11 incidences) reported that

violent attacks against nurses in health clinics occurred on daily bases but such attacks were at their highest on Mondays and Fridays. For example, Tygerberg reported 16 incidences on Mondays and 6 on Fridays, whilst Klipfontein had 11 incidences on Mondays and at least 5 on Fridays. Northern and southern sub-districts had the lowest incidences of violence against nursing staff. However, Thursdays were the quietest day of the week for nurses in all participating clinics.

In all the participating health community health centres, verbal abuse (86%) was the most common form of violence against nurses whilst threats to physically assault ranked second at 62%. Western and southern sub-district clinics nurses experience more verbal abuses compared to other clinics (100% and 83% respectively). Whereas Mitchells Plain (69%), Western (67%) and Northern sub-districts (67%) nurses received more threats to assault. Actual physical assaults against nurses were more frequent in Southern (68%) and Mitchells Plain (44%) than in other sub-district clinics. Most respondents (98%) confirmed that all categories of nurses irrespective of skin colour, ethnicity or religious affiliation were target of violent attacks. Large numbers of respondents (77%) maintained that violence against nurses working in community health clinics were on the increase.

Conclusion

In response to measure that could be put in place to assist nurses manage violence in community health clinics, respondents identified three key areas, i.e. assertive training, professional development programmes, and health and safety issues. All respondents agreed that assertive training workshops would equip them with the necessary skills to deal with violence in the workplace. Other nurses indicated that not all their professional colleagues were compassionate towards patients and that assertive training would not change those negative attitudes. Professional and in-service training programmes were identified as essential to upgrade nursing staff on new skills that would increase their confidence in dealing with aggression from health care consumers. Others recommended measures to increase security in the clinics, e.g. more security staff or police presence Monday and Friday clinic days.

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Educational goals
1. To share with participants types of violence directed against community nurses' working in the public sector.
2. To discuss days of the week that health care consumers violate community nurses.

Correspondence

Mrs Faizah Kajee-Adams
Faculty of Health Sciences, University of Cape Town
Private Bag X3, 7935 Observatory, Cape Town
7935
Cape Town
South Africa
+ 27 21 406 6346
kafajee@gmail.com

Adverse incident monitoring at a psychiatric hospital in South Africa

Paper

Yvonne Swart, Dana Niehaus, Liezl Koen, Elmien Macris
Stikland Hospital and the University of Stellenbosch, Bellville, South Africa

Background

Adverse incident monitoring forms part of a National Government initiative implemented at Stikland psychiatric hospital in 2003. The monitoring of adverse incidents is an important audit tool and allows for the early detection of trends by the Quality Assurance Manager at hospital and provincial level. Monthly, a summary of adverse incident reports are collected by Operational Managers and forwarded to Area Managers who audit the reports and then forward this to the Quality Assurance Manager. The Quality Assurance Manager (YS) collates a final monthly report for the hospital Quality assurance meeting. These reports are then summarized on a 3 monthly basis for the provincial quality assurance manager.

Aim

To report the number of adverse incidents specifically assaults (patient on patient and patient on staff, verbal assault excluded) at Stikland hospital for the period January 2005 to March 2009 and correlated this with seclusion and staffing patterns.

Method

Adverse incident reports for the period January 2005 to current were retrospectively reviewed and the number of assaults on staff and patients (by other patients and family members) were calculated for the period up to March 2009. The following adverse incident variables were collected: patient on patient assault, patient on staff assault, self-injury, suicide attempts, sexual abuse, damage to state property in addition to seclusion use and staffing ratios.

Results

Assaults (patient on patient) occurred on average 4.34 times per month (maximum 9 times per month) over this period. Patient on staff assaults occurred on average 7.17 times per month (maximum 14 times per month). There was significantly more seclusions in the female acute units (p<0.005; mean 78.86 per month vs. 50.69 per month) than in the male acute units.

Conclusion

There are a high number of physical assaults on staff at Stikland hospital, especially in the female acute units. It is important to investigate the reasons behind the high number of assaults and future studies should investigate different possible contributing factors including physical infrastructure of the wards, differences in prescription patterns and staff ratios (data collection ongoing and shall be presented) attitudes as factors may that be unit specific.

Educational goals
1. To illustrate the high number of assaults on staff working in high care psychiatric units.
2. To illustrate that gender differences may exist in assault patterns within high care psychiatric units.

Correspondence

Mrs Yvonne Swart
Stikland Hospital and the University of Stellenbosch
De La Haye
7530
Bellville
South Africa
+27219404455
djhn@sun.ac.za z

Health consumers' right versus nurses' right: Violence against nurses in Cape Town, South Africa

Seminar

Doris Deedei Khalil
Faculty of Health Sciences, University of Cape Town, Cape Town, South Africa

Introduction

Various writers had attempted to shed light on violence in the nursing profession. Some critical studies on violence against nurses were conducted within mental health or psychiatric institutions (Carlsson, Dahlberg, and Drew 2000; Antai-Otong 2001). Similarly, Armstrong (2002) reported of violence against nurses in Australia. Since then other studies had been conducted in Turkey, Kuwait, Saudi Arabia, United States of America, Singapore, and South Africa (Adib, AlShatti, Kamal, El-Gerges, and Al-Ragem 2002; Atawneh, Zahid, Al-Sahlawi, Shahid, and Al-Farrah 2003; Khalil 2009). Early and Williams (2002), and Donnelly (2006) presented findings of emergency nurses' experiences of violence. Fitzwater and Gates (2002) examined violence against nursing assistants working in nursing homes. These studies provides evidence that nurses had been increasingly dealing with both physical and verbal abuses from health care consumers (Kwok, Law, Li, Ng, Cheung, Fung, Kwok, Tong, Yen, Leung 2006; Khalil 2009). The first objective of the study was to identify types of violence directed against nurses. The second object was to identify perpetrators of violence against nurses. The third objective was to establish days of the week that violent incidences were at their height in the participating hospitals. The fourth objective was to elicit nurses' views on measures that would ensure their safety whilst practicing their profession.

Method

Confidential questionnaire survey of nurses working in eight public hospitals in Cape Town was utilised in collecting formation of experiences. The population was all nurses registered with the South African Nursing Council (SANC) and working in public hospitals in Cape Town, South Africa. Research participants were from three general hospitals, two psychiatric hospitals, two maternity hospitals, and a paediatric hospital. In accordance with the South African Constitution (1996), approval to conduct the study was granted by the University of Cape Town, Faculty of Health Human Ethics Committee and the participating hospitals' Research Committees. In addition, requests to approach nurse in the eight hospitals were granted by respective Directors of Nursing. To ensure confidentiality and anonymity, research participants were requested to refrain from identifying themselves on the questionnaires.

Results

Four hundred and seventy-one (471) nurses completed the questionnaires. Responses to closed-ended questions were captured and analysed on Microsoft Excel. Qualitative data generated from responses to open-ended questions were grouped for each question per participating hospital. The qualitative data per question was then grouped and compared for similarities and differences of experiences within participating hospitals.

To determine the extent that nurses encounter violence in clinical practice, it is essential to determine years of nursing experiences of participants. From the 471 participants, three hundred and twenty (n=320, 73.9%) had been nursing for more than 16 years. On the other hand, one hundred and thirteen (n= 113, 26.09%) had less than 16 years of nursing experience. Incidences of violence against nurses were verbal abuse (78%), threats to assault (58%) and actual physical attack (35%). Although it was evident that violence against nurses occurred daily within general hospital settings, incidences of violence would steadily rise from Thursdays through to Mondays during any given week. Nurses working in general hospitals reported the highest incidences of verbal abuse (n=173; 85.64%) compared

to psychiatric hospitals (n=103; 69.59%). Midwives and paediatric nurses reported the lowest incidences (n=71; 78.89% and n=22; 68.75% respectively). Similarly, threats to assault nurses were higher in general hospitals (n=117; 57.92%) than in psychiatric, maternity, and paediatric hospitals. However, nurse working in psychiatric hospitals (n=80; 54%) reported highest incidences of actual physical assaults.

Main perpetrators of violence against nurses in the eight hospitals were patients and patients' relatives. Within the general hospital settings, patients were responsible for 48% (n=125) of attacks against nurses whilst in psychiatric hospitals, incidences were 47% (n=72) and 52% (n=24) in the maternity hospitals. On the other hand, patients' relatives were responsible for 54% (n=110) of attacks against nurses in general hospitals; 47% (n=70) in psychiatric; 64% (n=52) in maternity and 58% (n=18) in paediatric hospitals. All respondents irrespective of areas of practice had experienced some form of violent from health care consumers. However, black and coloured (mix-race) nurses experienced more verbal abuses than other racial groups. Two hundred and seventy-four respondents (n= 274, 58%) reported that violence against nurses was on the increase in their respective specialist areas of practice.

Discussion

It is very rare to come across a nurse with over ten years of practice and had never experienced any form of violence during his/her nursing career. Majority of nurses all over the world are women and in some parts of the world, violence against women is an everyday occurrence. Results obtained indicated an aging nursing population in the eight hospitals with fewer nurses entering the profession. It was also evident that nurses working in the four specialist areas experienced violence on different days of the week. For example, although nurses working in general hospitals were verbally abused on daily bases, such incidences peaked on Sundays whereas within the paediatric hospital, violent incidences against nurses occurred on Saturdays. On the other hand, nurses working in maternity and psychiatric hospitals experience more violence on Fridays. Contrary to general perceptions, violence against nurses working in general hospitals was higher than against psychiatric nurses. Despite these observations, significant number of respondents (n=388) maintained that violence against nurses occurred everyday of the week especially during night duty.

Patients' relatives were reported to be primary perpetrators of violence against nurses in all participating hospitals. Majority of violations from patient relatives were verbal abuses and threats to assault. According to one respondent,

> "Nurses are subjected to all kind of abuses and sometimes violence from patients and their families, nurses are always wrong. But Professional Nurses (RNs) usually experience more violence because they tend to push patients around more than other categories - because they are in charge of the wards".

Some nurses tried to justify the violence stating,

> "Because of staff shortages and increased work load, some health care consumers become frustrated and take their frustrations out on the nurses. Most of the time, the experiences were verbal abuses or banging of doors".

In addition to abuses from health care consumers, some members of multidisciplinary health care team including doctors and surgeons also resorted to verbal abuse of nurses. A respondents working in theatre wrote,

> "It seems that other health professionals use nurses as their punch bags. It is OK for surgeons and anaesthetists if they are short staffed, but they do not want to accept it if they are told there is no nurse to assist with operations. Nurses experience verbal abuses from doctors especially if a surgical case does not go smoothly according to them. Nurses are expected to know each Doctor's preference. Theatre nurses are verbally mutilated and assaulted even though it is not their fault, for example, a surgeon assaulted an enrolled nurse (or Practice Nurse) assisting him in theatre. Some surgeons once they become consultants want to choose nurses that should scrub for them. Other doctors do not see the need for nurses to attend extra classes for professional development, e.g. computer skills".

From data collected, it was evident that violence was directed against all categories of nurses although verbal abuses were often directed against specific racial groups. The view of most respondents is that violence against nurses is on the increase and cited the following contributory factors:

1. Substance abuse and lack of respect for nurses

"Increase in substances abuse in the community and patients' disrespect of nurses. The community used to have more respect for nurses, today it is just a job but everybody is overworked".

"Loss of respect for nurses because the public has more rights and nobody is on the side of nurses. Communities are demanding better health care services that are not available due to shortage of staff, lack of equipments, no ambulances, and lack of responsibility on the part of clients' themselves".

"Everybody feels that nurses are easy targets. People outside the hospital sector always think that nurses are earning loads of money, so they think if they can attack them and get away with it".

2. Patients' rights versus nurses' rights

"People do not respect themselves as they used to. Patients and doctors do not appreciate nurses or nursing as a profession anymore, somewhere, somehow, the respect is out of the door".

"Violence against psychiatric nurses is accepted and nothing is done when a nurse is attacked because doctors feel that patients can not be held responsible for their actions. Patients are aware of the fact that they do have too many rights over nurses thus leading to increase in violence against nurses".

3. Inadequate preparation of nurses and negative publicity

"Nurses do not have the right training to protect themselves. Nurses are trained not to worsen the situation that is why people take advantage"

"Even the public do not recognise you as a nurse because nurses are always being portrayed as bad, but whenever something good happen in the nursing profession nobody talks to the media about it."

Despite views expressed above, 17 respondents' maintained that violence against nurses had been gradually decreasing because of increase security check points and visible security personnel at hotspot areas in public hospitals. Furthermore, despite evidence that health care consumers and their families are the main perpetrators of violence against nurses, it was acknowledged that minority of nurses were sometimes rude to patients' relatives resulting in unpleasant retaliations.

It was evident from comments that violence had been negatively affecting nurses in the participating hospitals. Feelings of despondency among nurses would engender low morale and culminating in exodus of nurses from the profession. Sharing such negative experiences with friend and family members would negatively affect recruitment of younger people into the profession. Some recommendations were firstly that the National Department of Health should make concerted efforts to educate the public on benefits of nurses in the health sector. Public education using community newspapers, television documentaries, in addition to posters at strategic points in public hospitals informing health care consumers of consequences of violence against nurses would minimise violations of nursing staff. The second recommendation is that health care consumers who violate nurses should be prosecuted (Coyne 2002). The third recommendation is that other health professionals that resort to verbally abusing and assaulting nurses should be made to account for their behaviour and apologise to their victims. Finally, although there had been significant increase in security at public hospitals, additional security were still needed.

If incidences of violence against nurses are not adequately managed, more nurses will be leaving the profession. On the other hand, counselling services are available in hospitals surveyed, some nurse-victims of violence do not utilize these services. The other alternative approach is to train nurses on simple self-defence techniques or improve their aggression management skills. One respondent's comment summed up aptly the feelings of most respondents.
"Violence against nurses is demoralising to the person, gives the feeling of dé jà vue, makes you stop loving what you are doing. You feel used and abused!"

Acknowledgements

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Educational goals
1. To raise participants' awareness of types of violence directed against nurses in Cape Town.
2. To share experiences of four specialist nurses› experiences of violence from health care consumers.

Correspondence

Mrs Doris Deedei Khalil
Faculty of Health Sciences, University of Cape Town
Private Bag X3, 7935 Observatory, Cape Town
7935
Cape Town
South Africa
+ 27 21 406 6346
Doris.Khalil@uct.ac.za

Aggressive behaviors in Alzheimer's patients: Tools for identification and non-pharmacological management

Workshop

Catherine Van Son
Washington State University, Spokane, Washington, USA

Older adults with Alzheimer's disease (AD) often exhibit agitated and aggressive behaviors. Staff in all healthcare settings are at risk for being a victim of AD patient's agitated and aggressive behavior. However, science has learned much in the recent decades about AD and although there is still not a cure, information on how to identify and manage behavioral issues are being developed. The knowledge and skills we currently have can reduce the incidence of these behaviors and protect staff from being victimized.

Alzheimer disease (AD) is a neuro-degenerative disease of the brain that causes changes in brain function. AD usually affects people over the age of 65 years, with a progressive decline in memory, thinking, language, and learning capacity resulting in behavioral changes. Age is the strongest predictor for the development and progression of AD and with our rapidly aging population, AD poses a major health problem. Nearly 35.6 million people in the world today suffer with dementia and by 2030 the number will be over 65.7 million (Prince & Jackson, 2009). AD disease is a complex disease and its management is challenging for clinicians and caregivers. Personality and behavioral changes, and the eventual inability to perform activities of daily living lead to dependence. As functional impairment deteriorates, healthcare utilization increases. Patients can remain in severe stages of AD for several years.

Over 90% of people with dementia will develop at least one behavioral symptom during the course of the illness (Ballard, Corbett, Chitramohan & Aasland, 2009). The frequency of agitation and aggression increases with the severity of the disease. Behaviors such as hitting, kicking, biting, swearing and screaming frequently occur during personal care. The prevalence of aggressive behaviors in persons with dementia is between 24% and 98% (Sourial, McCusker, Cole & Abrahamowicz, 2001). The effect of these behaviors on healthcare staff is challenging both physically and emotionally. In many settings, the treatment of agitation in AD is medications, in spite of the evidence that they are often not effective and cause significant adverse effects (such as increasing agitation).

Healthcare staff caring for cognitively impaired agitated/aggressive older adults are frustrated, distressed, exhausted, and fearful (Sloane et.al., 2004). To lower their job stress the incidence of agitated and aggressive behaviors by patient's with AD must be addressed in order for the incidence of violence toward healthcare staff to be reduced.

This workshop will review the knowledge and skills healthcare staff need to understand the disease and progression of AD and agitated/aggressive behaviors. In addition, the conceptual frameworks of Person-Environment Fit (Lawton & Nahemow, 1973) and Progressively Lowered Stress Threshold (Hall, 1988), practical interventions such as communication techniques, organizational, and environmental adaptations will be discussed and demonstrated. These interventions and adaptations can reduce triggers for agitated/ aggressive behaviors when providing care in the healthcare environment.

This workshop includes discussion, demonstration, video case studies and handouts, which participants can use to replicate the session in their healthcare organizations

Educational goals:
1. Discuss the relationship between Alzheimer's disease and agitated behaviors.
2. Describe interventions to identify and reduce agitated/aggressive behaviors in Alzheimer's disease.

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Correspondence

Mrs Catherine Van Son
Washington State University
103 E. Spokane Falls Blvd.
99210
Spokane, Washington
USA
+1 509 324 7254
vansonc@wsu.edu

Safety culture and violence prevention in the residential addiction treatment work setting

Paper

Jane Lipscomb, Kathleen McPhaul, Matt London
University of Maryland Baltimore, Baltimore, MD, USA

Workplace violence is endemic in the health care and social service workplace. The majority of studies examining the prevalence and risk factors for workplace assault in the health care sector have focused on the psychiatric and emergency care setting. Few studies have examined the social service workplace and to our knowledge, none have focused on residential addictions treatment centers. Therefore the purpose of this study was to examine the violence prevention safety climate measures and self reported violence toward staff in state-run residential addiction treatment centers.

In mid-2006, 409 staff from an Eastern United States state agency that oversees a system of 13 residential addiction treatment centers (ATCs) completed a self-administered survey as part of a comprehensive risk assessment. The survey was undertaken to identify and measure facility-level risk factors for violence, including staff perceptions of the quality of existing OSHA program elements, and ultimately to guide violence prevention programming. Key informant interviews and staff focus groups provided researchers with qualitative data with which, to understand safety climate and violence prevention efforts within these work settings.

The frequency with which staff reported experiencing violent behavior ranged from 37% for "clients raise their voices in a threatening way to you" to 1% for "clients hit, push, kicked, or struck you". Findings from staff survey included the following significant predictors of violence: "client actively resisting program" (OR = 2.34, 95% CI = 1.35, 4.05), "working with clients for whom the history of violence is unknown" (OR = 1.91, 95% CI = 1.18, 3.09) and "management commitment to violence prevention" reported as "never/hardly ever" and "seldom or sometimes" (OR = 4.30 and OR = 2.31 respectively), while controlling for other covariates.

We utilized a combination of qualitative and quantitative research methods to begin to describe the risk and potential for violence prevention in this setting. The prevalence of staff physical violence within the agency's treatment facilities was lower than would be predicted. Possible explanations include the voluntary nature of treatment programs; strong policies and consequences for resident behavior and ongoing quality improvement efforts. Quantitative data

Identified low management commitment to violence prevention as a significant predictors of staff reported violence.

Educational goals
1. Participants will be able to identify risk factors for violence in the Addictions Treatment Work Setting.
2. Participants will describe strategies for reducing violence in the Addictions Treatment Work Setting.

Correspondence

Mrs Jane Lipscomb
University of Maryland Baltimore
655 W. Lombards St.
21201
Baltimore, MD
USA
+1 410 706 7647
lipscomb@son.umaryland.edu

Occupational violence against Catalan healthcare professionals notified via Internet (2007-2009)

Paper

Josep M. Blanch, Genís Cervantes, Leonor M. Cantera
Department of Social Psychology, Universitat Autònoma de Barcelona, Bellaterra, Spain

Introduction

The currently available epidemiological data on workplace violence against health care workers provides evidence on its negative impact on the safety, health, and psychological wellbeing of victims, as well as on their personal and professional dignity, on the dynamics of their working teams, on the social climate of their center, on the image of the same health system, and on the quality of life of the general population (Camerino et al, 2008; COMB, 2004; Di Martino, 2002; 2003; Farrell et al, 2006; Gascón et al, 2009; Gerberich, 2004; Ryan & Maguire, 2006; Rumsey et al, 2007; Winstanley & Whittington, 2005). Therefore, international organizations interested in the quality of working life and wellbeing at work of these professionals offer guidelines for preventing workplace violence in the health sector (AMA, 1995; ANA, 2002; CIE, 2007, Di Martino et al, 2003; ILO; ICN; WHO & PSI, 2002; OSHA, 2004; Schopper, et al, 2006; WHO, 2003)

However, the application of these recommendations must take into account other empirical evidence accumulated: that workplace violence against health care workers is a complex, multifaceted, deep and global emerging process that shows a great variability between countries, professional sectors, departments and services. In this background, this research addresses a set of questions: Who does what to whom, where, when, how, why and for what? Therefore, this study aims to describe the typology and the frequency of the incidents of workplace violence against Catalan health care professionals recorded from July 2006 to June 2010, through an on-line reporting system, and to compare the collected data with the information given by contemporary research on the field.

Method

Population of reference:
In all the 60 Catalan health centers that took part in the project, mostly belonging to the XHUP organization (Network of Hospitals of Public Use) - were working, throughout the period 2006-2010, around 42.000 health care workers, of which 80% did so in acute hospitals, while 20% were distributed mainly in other types of health centers, in primary care and in mental health centers. Three quarters of this group were women, who occupied most of the places in nursing.

Procedure:
In the beginning of 2006 a network of health institutions was created. These institutions were voluntarily involved in the project and at the same time a Website www.violenciaocupacional.cat was implemented as the basis for the Occupational Violence Questionnaire which was answered through this site. In addition, each center assigned a professional belonging to their own organization. This professional was always a expert in occupational risk prevention, which mission was to report via the Web all the violent incidents occurred within the center. The protocol for the collection of information by such person during the period of reference included, among other steps, interviews with professionals who were victims of workplace violence and, sometimes, with witnesses or other people casually involved in the incident. The access to the Web was activated through a username and a password checked by the web-management beforehand. This expert received previous training and compromised himself to a confidentiality clause. Thus, each incident report was obtained on a confidential basis by answering the questionnaire as the incident was occurring. All the information was automatically incorporated into the project by the expert who was responsible to notify all the incidents that took part in each center. Besides this role he/she was in charge of given assistance to the victim by means of contacting the Mutual Occupational Accidents and Diseases Social Security System, and facilitating, if necessary, medical, psychological or legal support.

Instrument

To design the questionnaire, we carried out a selection of items according to psychometric criteria of theoretical relevance and representativeness (Alvaro, 1997; Camarero, 2004; Messick, 1992). To fulfill the first, we reviewed the literature in order to identify central issues concerning the problem. For the second (which is to ensure that the selected items represent important aspects of the semantic field of occupational violence in health sector), we submitted the draft questionnaire to an interdisciplinary committee of medical, psychology and nurse experts in occupational violence who have not been directly involved in its initial development.

The Occupational Violence Questionnaire included a typology of four categories of workplace violence against health professionals: (a) Verbal. Using the word for the abuser to offend, defame, discredit, ridicule, insult, threaten, bully or intimidate the victim. Usually occurs in face to face interactions and occasionally through telephone or internet messages, via SMS, written on paper or on the walls. Sometimes, it precedes, accompanies or follows other forms of aggression. (b) Physical. Body contact in the form of push, pull, kick, slap, punch, hit with some other body part, scratch, bite, pull hair, spit or attack with a blunt or sharp, and stab or fire through the use of any other object or substance capable of causing damage or injuries to the victim. (c) Symbolic. Subtle aggression by invading the personal space, intrusion in unauthorized places, or making intimidating gestures, displaying weapons, etc. which can be associated or not to verbal or physical violence. (d) Economic. Ownership deterioration or destruction of objects and belongings of the center or the staff, handling of instruments or furniture work of the institution etc.

The format of the questionnaire items is consistent with a model of multiple choice, some of which are single answer (census categories of sex, job title, etc.), and other are multiple choice response. For example, within the category of "verbal aggression", you can choose more than one response: "insult", "verbal threat", "verbal intimidation." The same can happen to questions related to "pretexts and reasons" of the incident, which also supports the choice of several responses (information, assistance, treatment, waiting time, medical discharge). Table 1 outlines the main sections of the questionnaire.

Table 1: Variables studied by Occupational Violence Questionnaire

Characteristics of incident	Variable
Assaulted Person	Age
	Sex
	Years working
	Care Division
	Professional Sector
	Type of contract
	Training received to coping with risk
	Background as a victim of occupational violence
Abuser Person	Age
	Sex
	Background of repeated aggression
	Antecedents of background pathology
	Usual care relationship with the person assaulted
	Number of offenders
Circumstances of incident	Date and time of the violent incident
	Shift
	Number of people attacked
	Place or service
	Type of Assault
	Excuse ("reason") for alleged violent behavior
	Psychophysical consequences for the person assaulted
	Intervention of security agents
	Actions taken against the aggressor

Results

From July 2006 to June 2010, out of a population of around 42,000 professionals, 2534 incidents were reported. As shown in Table 2, the majority of violent incidents included verbal aggression (sometimes that preceded and / or accompanied of other forms of violent behavior). A significant proportion of cases reported physical violence. The symbolic and economic violence also appear in a small but significant number of cases.

Table 2: Frequency and percentage of incidents by type of aggression

Type of Violence	Physical	Verbal	Symbolic	Economic	Total
Frequency	962	1940	399	63	3364
Percentage	28.6	57.67	11.86	1.87	100

In 421 cases, physical violence were accompanied by some other type of violence, in 395 incidents occurred in conjunction with verbal aggression, in 21 incidents occurred together with symbolic violence and in five cases together with some type of economic aggression. Tables 3 and 4 show frequencies and percentages of victims and of aggressors by sex. Female staff, around the three-quarters of the total reference population, was also the victim of 3 out of 4 of the reported acts of workplace violence. On the other hand, the aggressor was a man in more than sixty percent of cases.

Table 3: Frequency and percentage of incidents by sex of Assaulted Person

Sex	Frequency	Percentage
Woman	1909	75.34
Man	625	24.66
Total	2534	100

Table 4: Frequency and percentage of incidents by sex of Abuser Person

Sex	Frequency	Percentage
Woman	975	38.47
Man	1559	61.52
Total	2534	100

As shown in table 5, the majority of victims belonged to the professional category of nursing (more than half of all cases reported were nursing assistants or had a diploma in nursing). Within the medical sector, which comprises 20% of the reference population, almost 28% of incidents were reported.

Table 5: Frequency and percentage of incidents by professional sector

Professional sector	Frequency	Percentage
Administration	214	8.45
Nursing Assistant	598	23.6
Diploma in Nursing	759	29.95
Medicine	706	27.86
Other (technical, security, cleaning, cooking etc.)	257	10.14
Totals	2534	100

Taking into account the type of assistance program, during the four years of reference, more than half of the incidents were registered in hospital care, where around 80 per cent of the reference population was working. However, the highest relative percentage of incidents, as shown in Table 6, are: the Community Mental Health Centers (day care centers, clinics, etc.), and Hospital Mental Health (while only 2.61% of the population worked in this type of center, 14.68% of the cases were reported). Something similar can be said about the Management of Common and Professional Contingencies, Administration and Inspection services (2.76% of workers and 13.14% of the reported cases), and Ambulatory Care or Primary-Care Centers (3.98% of workers and 10.42% of the reported cases).

Table 6: Incidents reported from July 2006 to June 2010, according to type of service

Type of service	Incidents reported Frequencies (%)	People June 2010 Frequencies (%)
Ambulatory Care (primary care centers)	264 (10.42)	1700 (3.98)
Hospital Care	1307 (51.58)	34034 (79.58)
Management of Common and Professional Contingencies. Administration and Inspection	333 (13.14)	1180 (2.7)
Community Mental Health Centers (day care centers, clinics etc.) and Hospital Mental Health	372 (14.68)	1118 (2.61)
Health Partner, Residential, Homes, Private Foundations	224 (8.84)	3436 (8.03)
Other	34 (1.34)	1297 (3.04)
Total	2534 (100)	42765 (100)

The main "causes" and "reasons" of the violent episode reported by offenders are summarized in Table 7. For 341 out of 2534 of reported cases there is no accurate information about the "reasons" given by the abuser for their violent behavior.

Table 7: "Causes" and "reasons" of the violent episode reported by offenders

Justification (multiple choice question)	Frequencies	%
Timeout (for consultation, emergency etc.)	334	15.23
Information received by individual user or patient (perceived as insufficient, late, confused, contradictory etc.)	560	25.54
Dynamic care (frustration of expectations regarding treatment, prescriptions, laboratory tests etc.)	525	23.94
Interaction professional-patient perceived as negative, attributed to lack of empathy, of will or competence)	266	12.13
Discharge from hospital (in hospitals, social health and mental health) or back to work (in primary care centers and contingency management)	300	13.68
Other	208	9.48
Total	2193	100

43.17% of people reported having been assaulted and another 58.80% admitted not having received any specific training for coping with violent situations. In more than half of the incidents (56.79%), there was no usual health care relationship between the aggressor and the victim. In 72.22% of the reported cases, the offender is a patient who, in 90.5% of occasions, acts alone. In one third of the cases, the offender has already committed a previous offence. In addition, one third of the incidents happened in the context of some special "propitious circumstances" (psychiatric illness, drug addiction or alcoholism), under which appeared the recurrence in two out of three cases. Less than half of the cases showed involvement of colleagues or some sort of security forces. 19.30% of the reported cases derived in immediate concessions to offender demands (additional tests, medical transportation, etc.) In 4.10% of the incidents some form of formal legal proceedings was initiated. Few victims (1%) take time off work because the incident, but many of them (43.49%) declare to experiment a negative psychological impact resulting from the violent incident.

Discussion

Epidemiological data on occupational violence against health professionals are usually provided by self-report surveys, and occasionally by insurance, police or judicial records. Each of these techniques gives relevant information and involves some characteristic biases: while in insurance, police or judicial documents, the "physical" violence is normally over represented (Di Martino, 2002), self-report results are discussed because the big variability in response rates, and attending characteristics of the same self report methodology (Aragón & Silva, 2004; Donaldson & Grant-Vallone, 2002; Othmer & Othmer, 1996). This study applied a special technique for gathering information differentiated by the fact that only one professional person reported cases detected in each center. However, the comparison of the percentages of the main categories of violent incidents collected in this report (Physics, 28.60%, and Verbal, 57,67%) with data drawn from contemporary research on the field shows remarkable coincidences with those of Winstanley & Whittington (2004), who reported 27% (physical) and 68% (psychological) violence against healthcare workers in hospitals in the United Kingdom; of Kowalenko et al (2005) 28% and 75% in U.S. emergency physicians; of Kwok et al (2006) 18% and 73% in Hong Kong nurses; of Senuzum (2005) 19% and 98% in emergency department nurses in Turkey, but differs from those made by other reports, such as May (2005): 74% and 88% in nurses employed in acute care unit of a hospital in Florida. Coincidences are

also strong where compared to the data from a Spanish study of COMB (2002), which found 28% of physical violence and 70% of psychological one in the incidents reported by physicians from Barcelona. In the same way, Gascón et al (2009) reported 24% of physical assault and 59% of psychological violence (threatening behavior, intimidation or insults) experienced by health professionals belonging to a set of hospitals and of primary care centers from Zaragoza.

Conclusion

On the empirical domain, the collected data on the frequency and the typology of reported incidents by our on-line notification system are coincident with information given by contemporary research on the field. On the other hand, the quality of the present study is limited by its exploratory and descriptive nature. On the practical one, although occupational violence against health care workers has no justification whatsoever, it is worth considering that some of the most frequently "reasons" given to "justify" workplace violence in the health sector relates to the quantity, quality, timeliness and inconsistency of the information given to patients by the institution. It means that some risk factors of violent incidents could have to do with the structure and behavior of the organization. Perhaps one of the best ways of tackling this problem would be to improve the quality of the information as a preventive measure of workplace violence.

Also, to focus attention on physical violence, the most dramatic and immediately visible one, has led to minimize the psychological consequences of occupational violence. It is urgent to research this with greater interest. The agenda for our future research include the assessment of the medium and long-term psychological impact of occupational violence on their direct and indirect victims.

Acknowledgements

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Correspondence

Mr Josep M. Blanch
Department of Social Psychology
Universitat Autònoma de Barcelona
Campus UAB
08193
Bellaterra
Spain
+34 93 581 1326
jmbr47@yahoo.es

Development of coercive measures in a German psychiatric hospital over a period of nine years

Paper

Juan Valdes-Stauber
Bezirkskrankenhaus Kaufbeuren (Bavaria), Kaufbeuren, Germany

Introduction

The European Enlightenment period introduced mental illness into medical sciences and tried to understand divergent or even striking behaviour as part of mental disorders. Repressive policy was part of civil law to control societies, especially after foundation of modern nations. However, just after the Enlightenment period, Europe launched a wide action for building asylums to treat medically insane people as well as to preserve the public from potentially dangerous people (1). Other forms of violence against mentally ill people were coercive measures inside of hospitals. Both reasons for the application of coercive measures, namely medical treatment and control of violence related to mental illness are present until today (2). Sociological, medical and ethical issues claim psychiatry since the 1960s to clarify the dialectics between sympathetic help and authoritarian ordinance of measures for every single patient, particularly if there is a lack of insight for the need of a treatment. Psychiatry staff is confronted on a daily base with the ethical and medical questions of the use of compulsory measures when patients are endangering themselves or others (3). In this study, the development of the application of coercive measures is examined in a psychiatric hospital with full responsibility for the catchment area, particularly after an internal discussion about the ethical dimension of the use of compulsion in psychiatry, using different parameters. The hospital being researched participates in a benchmark evaluation project with ten other German hospitals (4).

Methods

Basic data of sector in charge:

The hospital is responsible for the full in-patient and out-patient psychiatric care of people with severe mental illness living in a catchment area of approximately 320000 inhabitants in a large rural South-Bavarian region. The district psychiatric hospital has 4000 admissions per year corresponding 1950 individuals with a readmission rate of 0.52 by an acute ward places rate of 0.5 per 1,000 inhabitants. Deinstitutionalization of long-stay patients was completed in 2003. The attached out-patient department is responsible for the ambulatory psychiatric care of individuals with severe mental disorders (4000 individuals per year), who cannot be adequately treated by the regular German primary psychiatric care system. This out-patient department is organized in seven specialized multi-disciplinary teams and was able to substantially reduce the mean length of stay over 25 years (5).

Investigated variables

We examine nine general variables related to coercive measures and five variables according diagnostic categories. For the first group of variables see Table 1. The second group comprised the following variables: 1. Number of affected patients by coercive measures; 2. Proportion of patients affected by coercive measures in each diagnostic category; 3. Development of figures concerning coercive measures according to diagnostic categories; 4. Annual number of coercive measures per affected individual according to diagnostic categories; 5. Mean duration of each coercive measure according to diagnosis.

Table 1: Descriptive analysis of investigated general variables (2001-2009)

	N	Min. - Max.	Mean	SD	SEM	Vc
Annual number individuals affected by coercive measures	9	126 - 235	188	29.7	9.9	0.16
Proportion of admitted individuals affected by coercive measures (%)	9	3.7 - 6.6	5.3	0.86	0.29	0.16
Annual number of coercive measures	9	585 - 1181	878	196	65	0.23
Annual number coercive measures per admission	9	0.16 - 0.33	0.25	0.05	0.02	0.21
Annual number of coercive measures per affected patient	9	2.77 - 7.12	4.81	1.21	0.47	0.29
Mean duration of each coercive measure (h)	9	3.17 - 7.88	5.48	1.78	0.59	0.32
Annual total duration of all coercive measures per affected patient (h)	9	16.1 - 43.5	27	9.7	3.2	0.36

Statistics

All compulsory measures carried out in the hospital were recorded between 2001 and 2009 using standard documentation. Data were aggregated and differentiated according to diagnostic categories. The number of compulsory measures and their duration were also recorded besides the number of persons concerned. The results were processed descriptively to show trends and underwent a Prais-Winsten-regression analysis to examine significant variations over the survey period. Bivariate and multivariate regression analyses between single variables were calculated. The investigation is prospective and imbedded in a multi-centric pilot project.

Results

Descriptive analysis shows a stable number of individuals annually affected by coercive measures (188) and the proportion of admitted individuals affected by coercive measures (5.3%). The annual total of coercive measures decreased especially in the last three years, as well as the proportion of annual coercive measures regarding all admissions and the number of yearly coercive measures per affected individual. The mean duration of each coercive measure doubled in the survey period, while in the same period the yearly total duration of all coercive measures per affected patient demonstrates a bell-shape. Variation coefficients (16 up on 36%) are not very high. Standard error of the mean vary between 5 and 10% of the mean values (see Table 1).

A bivariate regression analysis by Prais-Winsten-Regression with time as the regressor demonstrates a non-significant change of all variables over the survey period; however, there was no auto-regression (Durbin-Watson >1.64) for examined variables and R^2 was for four variables quite high (see Table 2).

Table 2: Prais Winsten regression analysis with time as regressor for all general variables

	rho	D-W	R2	b	Beta	t	p
Annual number individuals affected by coercive measures	-0.54	2.6	0.29	4.01	0.54	1.56	0.17
Proportion of admitted individuals affected by coercive measures (%)	-0.54	2.62	0.35	0.13	0.59	1.79	0.12
Annual number coercive measures	0.15	1.88	0.35	-44.8	-0.59	-1.78	0.12
Annual number of coercive measures per admission	0.08	1.86	0.39	-0.01	-0.62	-1.94	0.1
Annual number of coercive measures per affected patient	-0.08	1.94	0.42	-3.32	-0.65	-2.09	0.08
Mean duration of each coercive measure (h)	0.64	1.64	0.014	0.48	0.64	2.05	0.08
Annual total duration of all coercive measures per affected patient (h)	0.13	1.91	0.013	-0.46	-0.12	-0.29	0.78

The analysis of the reasons for application of coercion shows a decrease of coercive measures because of damage against objects and violence against others, the latter, however, not significantly. Self-harm became a more important reason for the use coercive measures (see Table 3). Fixation and isolation develop symmetrically as isolation decreases.

Table 3: Regression analysis with time as regressor for reasons for application of coercive

	rho	D-W	R2	b	Beta	t	p
Dangerous behaviour	0.5	1.93	0.05	0.37	0.25	0.64	0.54
Damage to objects	-0.71	2.25	0.55	-0.59	-0.74	-2.71	0.03
Violence against others	-0.26	2.08	0.29	-0.48	-0.54	-1.57	0.17
Menacing self-harm	0.05	1.94	0.13	0.75	0.36	0.94	0.38
Harm risk for oneself	-0.26	2.1	0	0.02	-0.01	-0.02	0.98
Self-harm	0.15	1.77	0.42	0.73	0.65	2.1	0.08
Other reasons	0.16	1.71	0.03	-0.7	-0.16	-0.41	0.69

We also examined the application of coercion according to diagnostic categories. There is a significant increase of affected individuals for dementia and other organic psychoses as well as for borderline disorders (see Table 4). No recognizable developmental pattern for the mean duration of each coercive measure at any diagnostic category was found. Over the survey period a narrower dispersion range within diagnostic categories was observed

Table 4: Prais-Winsten regression analysis with time as regressor for diagnostic groups

	rho	D-W	R2	b	Beta	t	p
F0	-0.44	2.11	0.56	2.46	0.75	2.75	0.03
F1	-0.64	2.11	0.29	-1.23	-0.54	-1.58	0.16
F2	-0.27	2.34	0.21	-1.45	-0.46	-1.28	0.25
F3	0.19	1.55	0.26	1.34	0.51	1.44	0.19
F4	-0.15	1.97	0.3	0.33	0.55	1.63	0.15
F6	-0.4	2.5	0.48	1.98	0.69	2.35	0.05
F7	-0.09	2.01	0	-0.01	-0.02	-0.04	0.96
F8	0.15	1.58	0.66	-0.33	-0.81	-3.43	0.01

Bivariate regression analysis taking auto-correlation into consideration shows that any variable significantly correlates with mean duration of coercive measures as dependent variable. We found for the number of coercive measures as a dependent variable significant negative correlations with number of yearly admitted individuals (Beta=-0.79; p=0.035) and yearly proportion of compulsory admissions (Beta= -0.98; p<0.001). In a multivariate regression analysis we also examined possible associations between different groups of regressors (concerning admissions, length of stay, out-patient treatment and compulsory admissions) and the annual total number of coercive measures in four statistical models. Neither the number of admissions and length of stay, nor the number of out-patients treated annually show a significant association with the number of coercive measures. Only the proportion of compulsory admissions shows a significant negative association with number of yearly total coercive measures (t=-9.83; p=0.002).

Conclusions

1. The *proportion of coercive measures* regarding all admissions continuously decreased since 2006, however not significantly, while the annual number of coercive measures almost halved over survey period.
2. *The mean duration of each coercive measure* increased symmetrically with the decrease in the proportion of *coercive measures per affected patient* almost significantly.
3. We found high proportions of coercive measures for F0, F2 and F6 and low proportions for F1, F3, F4, also a convergence for all trends by narrowing of ranges with the decrease in the number of coercive measures for all diagnostic categories, except F0 and F6.
4. In the last years self-harm has become a more important reason for the application of coercive measures (cf. (6)).
5. *The annual number of coercive measures* shows in bivariate regression analysis significant negative associations with the following variables: *Annual number of admitted individuals, Annual number of treated outpatients and the proportion of compulsory admissions.*
6. *The annual number of coercive measures* shows in multivariate regression models to have a significant negative interaction with *the proportion of compulsory admissions only.*

Summary

Some limiting points of this investigation include the following. A strong awareness for ethical implications of coercive measures existed before beginning of this investigation, consequently there is a weak pre-post effect. No nationwide benchmark initiative exists in Germany. Involuntary medication was not recorded separately in this study. However, the strengths of this investigation are the accurate data collection of coercive measures figures, the number of investigated variables, and the broad statistical analysis of the data.

The main message can be summarised as follows:
Institutional factors are possibly more powerful in explaining changes in the patterns of the application of coercion than diagnostic categories. A intensive ambulatory care shows to contribute to the reduction of coercion, perhaps because therapeutic relationship works preventively. Following compulsory admissions rates of coercive measures are lower in different statistical models, perhaps because of a more rapid saturation of the use of force in contemporary psychiatry.

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Educational goals
1. To promote awareness about the use of compulsory measures in psychiatry.
2. To explain the implementation of de-escalation techniques in psychiatric services.

Correspondence

Mr Juan Valdes-Stauber
Bezirkskrankenhaus Kaufbeuren (Bavaria-Germany)
Kemnaterstr. 16
87600
Kaufbeuren
Germany
+49 8341 724 503
juan.valdes@bkh-kaufbeuren.de

Patient-related violence against emergency department nurses: A review of the literature

Paper

Jacqueline Pich, Michael Hazelton, Ashley Kable, Deborah Sundin
University of Newcastle, Callaghan, Australia

Abstract

In a finding that reflects international experiences, nurses in Australia have been identified as the occupation at most risk of patient-related violence in the healthcare sector. A search of the literature was undertaken to explore this concept, with a focus on the Emergency Department and triage nurses.

High levels of violence are reported, with between 60 to 90% of nurses experiencing verbal and/or physical violence from patients. These high levels of violence have resulted in desensitisation on the part of many nurses to the point where violence has become an expected and accepted part of their job. Types of physical injuries sustained by nurses range from minor, (cuts and abrasions) to major (fractures and loss of consciousness). However, even in the absence of physical injury, nurses have been found to experience moderate to severe psychological reactions for up to 12 months after an episode of patient-related violence. These include Post-traumatic Stress Disorder and burnout and have been cited as a significant factor influencing intention to leave the profession. Patient-related workplace violence has negative implications not only for nurses themselves but for their patients, and may result in deterioration in the quality of care. Many measures in place for protecting nurses are superficial in nature and not directed at eradicating the problem, with an over-reliance on coercive traditional methods such as security guards and duress alarms. To overcome this, institutional change is required to facilitate prevention or minimisation of episodes of violence and to guarantee a safe workplace for Emergency Department nurses.

Educational goals
1. To facilitate an understanding of the factors associated with patient-related violence against Emergency Department nurses.
2. To provide an overview of the types of violence and frequency of episodes experienced by Emergency Department nurses.

Correspondence

Mrs Jacqueline Pich
University of Newcastle
University Drive
2308
Callaghan
Australia
+61 249 215 768
jacqueline.pich@newcastle.edu.au

Chapter 8 - Patterns of staff aggression and violence including horizontal and vertical violence, and gender and discrimination issues

Review of evidence regarding workplace violence

Paper

Lee Ellen Kirkhorn, Joan Stehle Werner, Melissa Heintz
University of Wisconsin-Eau Claire, Eau Claire, USA

Introduction

Horizontal violence has become a new epidemic in nursing practice. It has become universal, with 91% of respondents stating they have experienced some form of horizontal violence during their nursing career (Solfield & Salmond, 2003). 94% of nurses in a survey by the Association of Operating Room Nurses stated they had experienced verbal abuse at least once in the OR (Buback, 2004). Nearly one third of nurses experience some form of horizontal violence on a daily or near daily basis (Hegney, Plank, & Parker, 2003). Nearly 60% of new nurses will leave their first job within the first year and over half by the second year of their practice due to workplace violence (Griffin, 2004). With the cost of $16,000 to replace each lost nurse and organizations experiencing an average loss of 2.4 nurses per year to verbal assault, horizontal violence is hitting the medical field in the pocket book as well as effecting patient care through increases in errors and decrease in patient outcomes (Buback, 2004), (Jackson, Clare, & Mannix, 2002; Roberts, 2007; Duddle & Boughton, 2007). To date, proposals for management of horizontal violence have concentrated on the individual experiencing the victimization, which include assertiveness training, shared responsibility, and oppressed group theory (McLaughlin, Bonner, Mboche, & Fairlie, 2010; Roberts, 2007; Solfield & Salmond, 2003; Duddle & Boughton, 2007; Hutchinson, 2009). Yet, when questioned, only 20% of the respondents stated that they felt that management was concerned over their experience with horizontal violence (Massachusettes Nurses Association). Health Care settings need to generate new models to manage episodes of workplace violence and provide much needed education and strategies to change the workplace culture. The status quo is perceived as tolerating and even perpetuating this behavior (Duddle & Boughton, 2007; Solfield & Salmond, 2003; Roberts, 2007; Buback, 2004).

The concept of workplace or horizontal violence is difficult to define, as there are many terms that have been used interchangeably in the literature such as; bullying, marginalization, verbal abuse, mobbing and victimization. Often these terms have been used interchangeably or their definitions have coincided. This has made it difficult for research to compare and contrast findings. For the purposes of this presentation we will use the terms horizontal and workplace violence, as it appears to encompass a majority of the concepts included in each definition. The behaviors involved in workplace violence are also often largely subjective and are based in perception (Aquino, Grover, Bradfield, & Allen, 1999); criticism, sabotage, undermining, scapegoating, non-verbal innuendo, backstabbing, withholding information, gestures, gossiping, belittling, blaming, public humiliation, refusal to assist, impossible demands, excessive or too light workload are a collection of the behaviors involved (Rocker, 2008) (McLaughlin, Bonner, Mboche, & Fairlie, 2010; Lee, 2000).

Workplace violence experienced by nurses has been perpetrated by fellow nurses, nurse managers, administration, as well as other practitioners within the facility The effects of these experiences on the individual include physical as well as psychological signs and symptoms, some that are consistent with Post Traumatic Stress Disorder The ONA stated that horizontal violence has now been cited as the major cause of nurse burnout (2001). Responses to individual experiences of workplace hostility are anger, powerlessness, harassment, embarrassment reductions in confidence and self esteem, anxiety, sadness, depression, frustration, nervousness, and over time often lead to isolation, fear, stress related illnesses, and even suicide (Rocker, 2008; McKenna, Smith, Poole, & Coverdale, 2003; Solfield & Salmond, 2003).

The health care facility where workplace violence occurs experiences decreasing morale, increasing job dissatisfaction and creating a hostile work climate, inhibiting teamwork, affecting the efficiency, accuracy, safety and outcomes of care, poor work performance and increases the intent to leave not either the ward, the facility or the field of nursing completely (Sheridan-Leos, 2006) (Solfield & Salmond, 2003). 44,000-98,000 people die every year in U.S. Hospitals because of medical errors, therefore it is in the best interest of the facilities to provide a working atmosphere that is conducive to increased productivity, decreased medical errors, and that is promoting of teamwork (O'Daniel & Rosenstein; Medicine, 2000) Developing a zero tolerance and placing policies and procedures to not only manage workplace hostility but to prevent it needs to be the goal of healthcare organizations today.

Internationally, Countries such as Canada, the UK, and Scandinavian countries have enacted laws to protect workers from types of workplace violence. Australia and New Zealand have embarked on numerous studies in nursing to research the occurrence and effects that horizontal violence has on the individuals as well as the organizations. Currently, the United States has laws protecting the physical safety of employees, overseen by the Occupational Safety and Health Administration; as well as the 14th amendment protecting employees from discrimination and sexual harassment. As of yet, there are no laws providing protection from non-physical workplace violence. There continues to be an increase in the research and publication on workplace violence, with many facilities creating and installing zero-tolerance policies. This issue is being examined much more closely with calls for reform being heard internationally.

Making a change in the environment and the culture of a facility, as well as the individual units within a facility will require systemic change. We propose that organizational and individual change theories shed light upon processes that will bring radical change to the status quo. An examination of Blanchard's Model of Change additionally provides insight into how an individual nurse perceives change and its effects upon the environment where they are practicing. With rising health care costs, less funding, and nursing shortages; it becomes important to concentrate on ways to create a harmonious workplace. Nurses not only need to be the givers of care but also the recipients of care, with a respectful work environment that is conducive to optimal patient outcomes.

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Educational goals
1. Discuss ways to prevent violence in the workplace.
2. Describe the nature and extent of workplace violence across settings.

Correspondence

Mrs Lee Ellen Kirkhorn
University of Wisconsin-Eau Claire
1412 Nixon Avenue
54701
Eau Claire
USA
+1 715 836 5005
Kirkholc@uwec.edu

Horizontal violence on certified registered nurse anesthetists (CRNAs): A study of prevalence and impact

Poster

Ruth Ticknor, Barbara Penprase, Lisa Mileto
Vermont Technical College, Randolph Center, USA

Abstract

Horizontal violence or interpersonal conflict with verbal abuse is a very real entity within the healthcare provider arena. The phenomenon has been researched in nursing over the past two decades by nurse researchers and social science researchers. While stress and work relationships have been topics of research in the nurse anesthesia literature, there have been no studies examining the prevalence and impact of horizontal violence in the CRNA work environment. The literature illustrates that horizontal violence within the operating room environment is common, and CRNAs are exposed to this milieu everyday. The purpose of this pilot study was to describe the prevalence of horizontal violence within the work environment of the CRNA. In addition, the impact of such phenomena upon the CRNA is examined.

In this randomized, descriptive study, a survey tool was utilized to obtain demographic data as well as qualitative information regarding experiences with horizontal violence. The sample for this study was drawn from the active, practicing CRNA membership of the AANA.

The study demonstrates the existence of various forms of horizontal violence within the CRNA's work environment. In addition, the study illustrates the impact these incidences have upon CRNAs.

Educational goals
1. Describe various forms of horizontal violence in the CRNAs' work environment.
2. Illustrate the impact that horizontal violence has upon the CRNA.

Correspondence

Mrs Ruth Ticknor
Vermont Technical College
PO Box 500
05061 Randolph Center
USA
+1 802 728 1000
rlt72364@earthlink.net

Workplace violence, gender discrimination and steps towards health systems reform in Rwanda

Paper

Constance Newman, Jeanne d'Arc Kanakuze, Daniel De Vries, Gerard Ngendahimana
IntraHealth International, Chapel Hill, North Carolina, USA

Abstract

Background: Workplace violence has been documented in all sectors, but female-dominated sectors such as health and social services are at particular risk. Though it has been noted that workplace violence and gender discrimination are associated and should be addressed simultaneously, the relationship between the two needs further delineation. In 2007- 2008, IntraHealth International assisted the Rwanda Ministry of Health to study that relationship in its health sector [1].

Methods: The study covered three districts chosen randomly from each of Rwanda's five provinces, for a total of 15 districts. Researchers selected 44 facilities from which they drew a sample of 297 health workers—205 women and 92 men. Researchers used interviews, surveys, facility audits, and focus groups to collect data and measured discrimination through subjective and objective measures.

Results: The study found that 39% of health workers in the sample had experienced some form of workplace violence in the last year: 27% experienced verbal abuse, 16% were bullied, 7% encountered sexual harassment and 4% were physically assaulted. The main perpetrators of violence were colleagues and hierarchical superiors. Men perpetrated most acts of violence (including sexual harassment, bullying, and physical violence), while women perpetrated most acts of verbal abuse. The experience of violence was associated with psychological health impacts and absenteeism. Negative stereotypes of women, discrimination based on pregnancy, maternity and 3 family responsibilities, and the "glass ceiling" all affected female health workers' experiences and career paths. Health workers' perceptions of gender equality within the workplace were associated with reduced levels of violence.

Conclusions: Because the key factors contributing to the emergence of violence in Rwandan health workplaces were institutional and behavioral, it is likely that improved HR policy and management practices could ameliorate some of the risks for violence. Workplace violence research should routinely measure the extent of systemic gender discrimination at work. Specific forms of gender discrimination should be special concerns of HRH and workplace violence policies, strategies, laws and HR management training. Acting on all of the foregoing will go a long way in reforming health systems in the direction of greater safety and gender equity for its workforce.

Background

Workplace violence—often manifested through physical assault, verbal abuse, sexual or racial harassment, bullying or mobbing—affects occupational health worldwide [2]. The publication of research results of the ILO, WHO, ICN and PSI Joint Programme on Violence in the Health Sector in 2002 officially brought the issue to the forefront. [3]. This and other contemporaneous studies demonstrated the various effects and consequences of violence at the individual, organizational, and societal levels, noting that such incidents disrupt fundamental freedoms and rights in the workplace and often lead to depression, anxiety, physical disability, resignation, dismissal, transfer, absenteeism, lowered quality of care, decreased workplace productivity, increased costs to health systems, or even death [5]. In almost all studies on the subject, the magnitude of psychological violence appears to be greater than that of physical violence.

Incidents of violence in the workplace occur in all sectors, but female-dominated sectors such as health and social services are particularly vulnerable [6, 7].Experts in the field acknowledge the role of gender and appear to consider acts of workplace violence to be "gender-based." (Note: The terms "sex" [a biological and physiological attribute] and "gender" [the social construction of men and women] are often used interchangeably. In this paper, the authors use the term "gender discrimination" to include both sex and gender-based discrimination.) A fact sheet from the International Council on Nursing (ICN) notes that "Ninety-five percent of nurses around the world are women. Attitudes towards women are often reflected in interactions with the profession" [8]. The ICN further noted that "women are targets of violence more often than men. They are subjected to domestic and workplace violence, manifested through physical and verbal

abuse, sexual harassment and bullying" [9]. The Joint Programme Report also observed that, while both men and women seemed to be at risk, women were the victims in the majority of cases of workplace violence simply because the majority of workers in the health sector are women [10].

Few studies have directly measured gender discrimination beyond sexual harassment. More recent research has attempted to analyze gender as a factor increasing health worker vulnerability to or in the commission of workplace violence [11]. Baines' research was particularly relevant, having explored the link between women's vulnerability to violence and the gendered division of labor where women are concentrated in jobs at greater risk of exposure to violence, such as health workers facing clients who are angry, frightened or in distress. This qualitative research even drew parallels between the gender dynamics of professional caregiving and intimate partner and sexualized violence [12].

While it is held that discrimination can lead to the targeting or vulnerability to violence of girls and women [13] and that both problems should be addressed simultaneously [14], the link between gender discrimination and workplace violence in the health sector needs further delineation. Reform and prevention efforts within the health system can be strengthened if specific types of gender bias or discrimination can be identified as cause of or contributor to workplace violence. First, even though male and female workers may be equally exposed to workplace violence, it may have a greater or different impact on female workers if discrimination limits one's options, including seeking redress [15]. Second, more specificity can help HRH professionals develop appropriate and targeted HR policies and actions that make health systems safer and more equitable for its service providers. Between 2007 and 2008, IntraHealth International assisted the Rwanda Ministry of Health in exploring workplace violence and gender discrimination in Rwandan workplaces.

Methods

To increase stakeholder ownership of the study and the likelihood that results would be used for subsequent HRH policy-making and planning, researchers used a utilization-focused approach that involved multi-sectoral stakeholders in all aspects of the study, The research team worked with a steering committee, (whose core members were representatives from the Rwanda Ministries of Health, Public Service and Labour, Gender and Women's Promotion, Justice, and the Rwanda Health Workers' Union) to design the research study, and to interpret and disseminate results. Formative research was conducted in early 2007 and consisted of interviews with policy makers, a focus group with health personnel, and a review of national labour and gender policies. This research informed the development of data collection instruments; the identification of avenues of data analysis; and the generation of culturally appropriate definitions of violence and gender discrimination, including behaviours associated with each definition. Data collection took place in July 2007, and combined qualitative and quantitative approaches to document prevalence of violence; individual, organizational, and societal risk factors; and to explore the relation between gender discrimination and violence at work. Sampling occurred in fifteen districts (three per province) selected randomly for the study from each of the five provinces of Rwanda. Within each district, three health facilities were selected at random to obtain a sample of 297 health workers (205 women and 92 men) from a total of 44 facilities. The sample included specialist and generalist physicians, nurses, nurse-midwives, midwives, nutritionists, laboratory technicians, radiologists and social workers. Table 1 shows a summary of the tools used and respondents.

Table 1 - Number of Study Respondents by Sex and Geographic Residence and Study Tool

Category	Sex			Residence		
	Men	Women	Total	Urban	Rural	Total
Health Workers Survey	92	205	297	158	139	297
Facility Directors / Heads Interview	14	9	23	6	17	23
Key Informants Interview	14	15	29	29	-	29
Health Workers Union and Labor Inspectors Interview	8	1	9	7	2	9
Patient Focus Group Discussion	52	59	111	56	55	111
Total	180	289	469	256	213	469
Facility Risk Assessment Inventory				44	31	13	44

Qualitative data were analyzed for content and trends to inform the quantitative survey results. Interview data were collated by Rwandan consultants in a database and analyzed using Excel. Quantitative data were analyzed with a basic statistical package using simple cross-tabulation and correlation, as well as logistic regression. Because the data were based on retrospective survey of self-ascribed respondent behaviour over the past year, findings should be taken with caution, as a response bias is likely to be of some influence. However, to minimize response bias, culturally appropriate tools in local language were used and data were obtained by experienced and trained data collectors. The process of informed consent was rigorously followed for each respondent and if needed, referrals were provided to psychological support services. The

innovative study methodology measured the individual, organizational, and cultural variables and contexts of violent events, including forms of gender discrimination not measured in previous studies of workplace violence. The researchers studied gender discrimination by examining qualitative analyses of perceived discrimination and inequality, and quantitative, objective data such as the number of men and women occupying the most senior positions in an institution.

Researchers experienced some challenges in documentation. First, de facto discrimination may exist, but reporting may be inhibited in situations where official policy and public rhetoric strongly favor gender equality and non-discrimination, or when discrimination—like violence—is normalized. Second, de facto gender discrimination may exist, but may not be perceived or appraised because subjects of discrimination may lack direct evidence. This may be seen in the case of vertical segregation of top health management, where study respondents did not have objective data on the extent of male overrepresentation in the highest health management tier. Because discrimination may exist but may be normalized or not be perceived, future research should explore manifestations of gender discrimination and violence that can be captured by qualitative and quantitative means. Perceptions of discrimination may be linked to objective measures such as salary data, training opportunities, sex composition of top management positions and analysis of the allocation of work tasks and workloads.

Results

The Nature and Consequences of Workplace Violence

Violence was a real problem in Rwandan health workplaces and was perceived as such. Approximately 39% of health workers reported experiencing at least one form of workplace violence in the 12 months prior to the study. Ten percent of health workers had experienced one form of violence on the way to or from work, and 59% had witnessed at least one form of violence.

Table 2 displays prevalence by sex and type of violence. Verbal abuse was the most prevalent form, and physical violence the least prevalent. This reflects the researchers' observation from reviewing the literature that the magnitude of psychological violence (including bullying, verbal abuse and non-physical sexual harassment) is greater than that of physical violence. Men and women seemed to differ in the types of violence they experienced. The data showed that men and women exposed equally to all forms of violence at work except for sexual harassment, which was almost twice as prevalent among female health workers (9%) as male workers (5%).

Table 2: Prevalence by Sex and Type of Workplace Violence (N=297)

	Prevalence		
Type of Violence	All health workers	Women	Men
Verbal abuse	27%	27%	25%
Bullying	16%	15%	19%
Sexual harassment	7%	9%	5%
Physical violence	5%	4%	5%

The majority of perpetrators of workplace violence were health staff, followed by hierarchical superiors. Patients, their families, or the general public comprised smaller proportions. In the case of sexual harassment, however, members of the general public perpetrated nearly 47% of the incidents. Men committed most acts of workplace violence, including 70% of the incidents of sexual harassment, 62% of the incidents of bullying, and 58% of the incidents of physical violence. Women perpetrated most acts of verbal abuse (62%).

Reactions to and Consequences of Workplace Violence

Table 3 displays health workers' reactions to the experience of workplace violence. In the wake of an incident, most either did nothing or considered quitting their job, which suggests that workplace violence may be normalized in Rwandan health workplaces.

Table 3: Reactions to Workplace Violence (N=159)

Reaction	Male HCWs (N=48)				Female HCWs (N=111)			
	Verbal abuse (n=24)	Physical violence (m=4)	Bullying (n=16)	Sexual harassment (n=4)	Verbal abuse (n=36)	Physical violence (n=7)	Bullying (n=31)	Sexual harassment (n=17)
Did Nothing	61%	40%	50%	80%	50%	83%	39%	47%
Thought of quitting	35%	60%	50%	20%	46%	17%	52%	47%
Quit the job	4%	0%	0%	0%	4%	0%	10%	7%

Health workers' disclosure of incidents varied with the type of violence. In most cases—especially those of verbal abuse, bullying, and physical violence—subjects disclosed the incident to colleagues. But in 40% of sexual harassment cases, the victim did not disclose the occurrence to anyone. Further, fewer than 20% of victims of most forms of violence reported the incident to their supervisor; in cases of bullying, though, 34% of victims reported the occurrence. This low reportage rate is not surprising, given that hierarchical superiors were reportedly perpetrators of all types of violence. When asked if the supervisor or the director of the facility took measures to help the victim or to respond to violence, only 30% of health workers agreed.

The victim's psychological health was the most critically impacted by acts of workplace violence. On average, victims of bullying were absent from their jobs longer than victims of other types of violence (four day's absence in the last year), followed by victims of verbal abuse (three and a half day's absence), physical violence (three day's absence) and sexual harassment (three day's absence). Finally, the qualitative data from the health workers survey point to individual and organizational consequences of workplace violence, such as disturbed interpersonal relations, a feeling of lower energy and decreased productivity. Workers had obsessive thoughts and a range of feelings, such as trauma, hatred or fear regarding the perpetrator, a loss of confidence or dignity, a wish to isolate or protect oneself, anxiety, depression and anger after incidents of violence. For example, one respondent noted "I will no longer talk to him [the perpetrator]. I want to work but without any contact with either my colleagues or my supervisor." Another stated that, after an incident of workplace violence, "I wanted to stop working," while another remarked that the incident still "makes me frightened all the time."

The Role of Gender Relative to Other Contributing Factors

Rather than the characteristics of individual workers (such as age or seniority), the most important contributing factors in the emergence of violence were institutional and societal, including the level of workplace security, gender inequality, and the lack of a culture of mutual respect. Based on exploration of variables which showed trends towards significance, a logistic regression model was created with the variable "experience of violence" as dependent variable with no-prevalence as the reference category and eleven independent variables. A significant overall model (Chi2(33)- 99.95, p=0.00) was found which explained 25% of the variation (Pseudo R-sq=0.25) and which had an adequate fit. The model is shown in Table 4.

Table 4: Logistic Regression Results of Prevalence of Workplace Violence.

Type of variable	Variables of significance in the aggregated model of violence both at work and during travel to and from work	Sign. (p)	Odds Ratio (Exp(B))	Inverse of Odds Ratio (if decline)
General	Religious Sector (compared to Government)	.02	4.7	
	Social Worker (compared to Nurses)	.07	0.3	(3.4)
	City (compared to Rural)	.01	11.8	
	Southern Province (compared to the North)	.00	0.1	(10.9)
	Kigali City (compared to North)	.01	0.1	(13.7)
Facility Security	Signs posted to indicate staff-only break areas (as compared to no signs)	.04	2.7	
	Entrance to the building is easily seen from the street and free of heavy shrub growth (as compared to entrance not being visible)	.00	0.1	(11.5)
	High level of perceived respect which patients show to staff at workplace (compared to low level of respect)	.07	0.7	(1.4)
Culture of Respect	High level of perceived respect supervisors and staff show to each other at the workplace (compared to low level of respect)	.03	0.6	(1.6)
	Perceived equal chance for men and women to get hired for jobs for which they are qualified in the health sector (as compared to unequal chance)	.01	0.2	(6.1)
Gender Equality	Different perceived consequences of workplace violence for women and for men (as compared to same consequences)	.08	0.4	(2.3)
	Perception of equal treatment at work received by men and women (as compared to unequal treatment)	.02	0.2	(5.4)

The "Odds Ratio" column describes the level at which the odds of workplace violence increased or declined relative to a variable. When the odds were above one, the variable increased the odds, and below one, the variable declined. After the general factor of facility placement and the visibility of the facility entrance, the logistic regression highlights the importance of the gender variables. When men and women have an equal chance to get hired for jobs for which they are qualified, the odds of violence are calculated

to be six times lower (0.2) compared to the situation when there is no equal chance. Further, when men and women receive equal treatment at work, the odds of workplace violence are about five times lower (0.2) compared to the situation in which there is no equal treatment. The culture of respect variables are of lesser importance compared to the gender variables, even though respect does lower workplace violence. The gender equality variables were thus considered as the more influential behavioural contributor to reduced workplace violence. Figure 1 graphically depicts that perceived equal treatment at work was associated with a reduced percentage of health workers experiencing workplace violence.

Figure 1: Perception of an equal chance to get hired for jobs
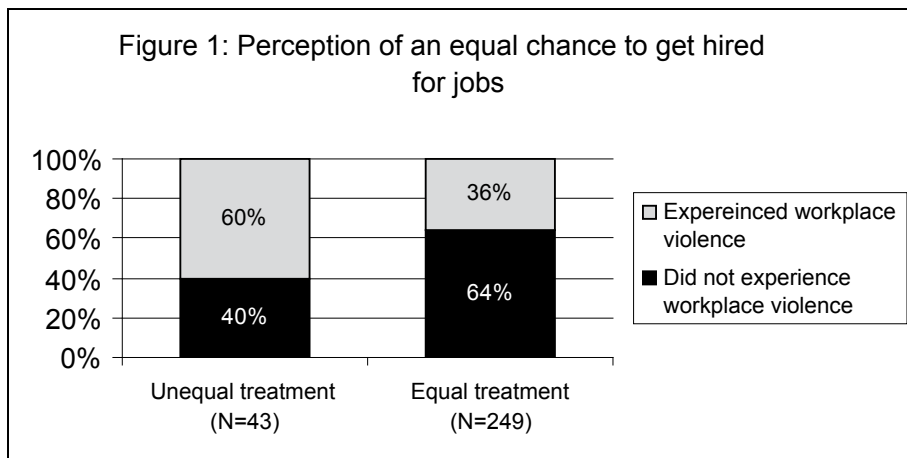
Sixty percent of respondents who perceived unequal treatment also indicated that they had experienced some form of workplace violence, compared to 36% of those who perceived equal treatment (Pearson chi2(1) = 9.388, P = 0.002).

Further, Figure 2 shows that the perception of an equal chance to get hired for jobs for which the worker is qualified is associated with a reduction in the percentage of health workers experiencing workplace violence. Sixty-two percent of respondents who perceived inequalities in the hiring process indicated that they had experienced some form of workplace violence, contrasted with 35% of respondents who had perceived equal chances for both men and women (Pearson chi2(1) = 11.639, P = 0.001).

Figure 2: Perception of an equal chance to get hir for jobs
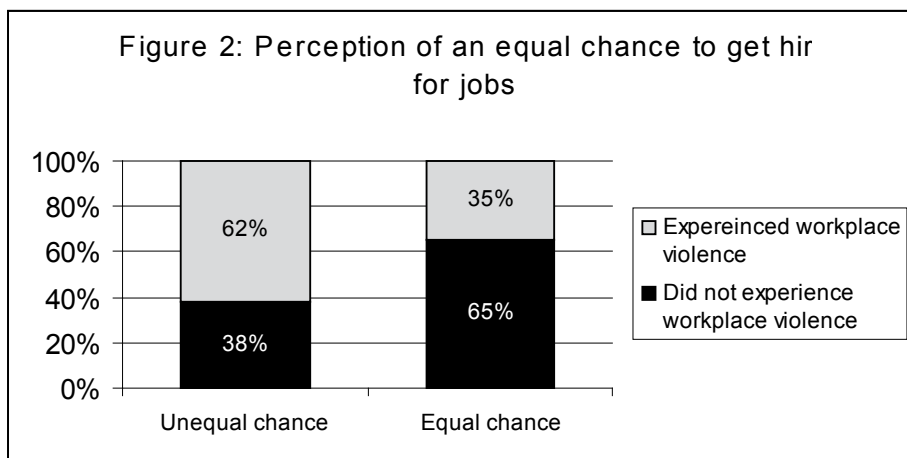
Gender Discrimination and Workplace Violence

The qualitative and quantitative data suggest that female health workers' experience of problems at work are recognized forms of gender discrimination and that they co-occurred with violence.

Discrimination based on pregnancy and family responsibilities: The researchers asked health workers whether they agreed or disagreed that various forms of discrimination occurred at work. Forty-nine percent of respondents agreed that women did not encounter the same problems as men at work and 41% agreed that women were more exposed to violence. Sixty-eight percent of respondents pointed to pregnancy, childbirth, and family and child care responsibilities as factors that prevent women from fully participating at work. Qualitative data from the health workers' survey also suggested that female workers perceived their career progress to have been adversely affected by the unique problems faced by women at work. Some surveyed female workers perceived their performance evaluations or opportunities for promotion had been influenced by their maternity status; others perceived they were demoted after pregnancy without cause, or were not hired for a position because of presumed future pregnancy and negative performance appraisal. One respondent noted that "When I had not yet delivered, I was deputy director; after delivery, I was demoted for no reason but I think it was because of my pregnancy."

Occupational segregation: The study revealed vertical segregation of the facility director's job by sex. Survey responses were analyzed with attention to the number of men and women in the top management jobs. While only 16% of health workers in the survey sample believed that women did not have the same chance as men of being hired for jobs for which they are qualified, women actually did not appear in the top management jobs at the same rates as men. Even though men made up only about 31% of the sample, they constituted 60% of directors in the sample facilities. These results suggest that vertical segregation is not necessarily perceived. Further, about one out of four service providers agreed that task assignments for male and female workers occupying the same job differed either in types or volume, suggesting some gender segregation of tasks. As a female study participant noted, "Some people seem to think that certain activities are reserved only for men."

Negative stereotypes of female workers: Sexual harassment, problems at work related to pregnancy and family responsibilities, and occupational segregation co-occurred with negative stereotypes about female health workers, such as an unwillingness to speak up, weakness, indecisiveness and incompetence. One survey respondent observed that women at work "just don't know how to make decisions in a sure and certain way." Another noted that women "are not even capable of pulling out a tooth." These negative stereotypes may be the foundation on which violence (as well as other forms of workplace discrimination) rest. According to a key informant, beliefs about Rwandan women in the health workplace rationalize violence: "There is a tendency to say that women are weak in the broadest sense … and, in some cases, the violence that women are subjected to stems from this situation." The participatory, capacity building approach increased policymakers' ownership of the results and the impact of the study. Results contributed to the revision of the national Law Regulating Labor in Rwanda and plans to revise the national Gender - Based Violence Policy.

Discussion

The study shed light on the types, and consequences of, and reactions and contributing factors to, workplace violence. Workplace violence is a real and apparently normalized phenomenon within the health sector in Rwanda with individual, organizational, and societal impacts experienced by 39% of the health workers sampled. Male and female staff experienced violence, but mostly did nothing or only thought of quitting after the experience. The study results suggest a key linkage between gender inequality and workplace violence, and supports the contentions that discrimination contributes to violence and that both should be dealt with simultaneously.

The study identified particular forms of gender discrimination that appear to be contributors to workplace violence against female workers. Sexual harassment co-occurred with problems related to managing pregnancy, motherhood and work, and negative stereotyping. The results on the over-representation of men in top management and gender-based task assignment point to occupational segregation, a ubiquitous form of gender discrimination that typically results from multiple and accumulating discriminations during childhood, schooling, and entry into a career. Vertical segregation may also be taken as a manifestation of pregnancy discrimination which, by using social and biological attributes for employment decisions, impacts female workers' career progression and ultimately weakens women's ties to the health workforce. The fact that female health workers appear to have experienced more than one type of discrimination and bias suggests a systemic substratum of gender discrimination in the health workplace that deserves serious attention from HR policy makers and managers.

A key finding was the extent to which gender equality lowers the odds of experiencing violence at work, or put in another way, how gender inequality at work increases the odds of violence. Study results suggest that violence in the health sector 16 comes about from a "category bias" [16] in which violence against female health workers is but one component of the wider problem of gender discrimination that denies

women the opportunity to exercise employment rights and economic freedoms based on their biological and social roles.

Conclusions

Gender discrimination and inequality contribute to violence in the health sector. Because the key factors contributing to the emergence of violence in Rwandan health workplaces were institutional and behavioral rather than individual, it is likely that improved HR policy and management practices could ameliorate some of the risks for violence. First, workplace violence research and workforce assessments should routinely measure the extent of systemic gender discrimination at work. Second, gender inequality, bias, and specific forms of discrimination should be special concerns in the development of both HRH and workplace violence policies. HRH policies should protect women against losing seniority, promotion prospects, or a job as a result of pregnancy or caring for children and family members. Countries that are signatories to international consensus documents on gender equality, such as the ILO's four gender equality labour standards, already have a policy context for policy and legal reform. Sectoral strategies should challenge gender stereotypes, discriminatory behaviour, and all forms of violence against women. Finally, HR managers should operationalize non-discrimination and anti-violence policies in workplace guidelines and codes of conduct and should vigorously enforce them. Training HR managers to identify discrimination and manage the risks of violence in the workplace should be high on the list of any programmatic response. Acting on all of the foregoing will go a long way in reforming health systems in the direction of greater safety and gender equity for its workforce. This is likely to increase the productivity of the health workforce.

Abbreviations

WHO: World Health Organization; HR: Human Resources; HRH: Human Resources for Health; HRM: Human Resources Management; ILO: International Labour Organization; ICN: International Council for Nurses; MOH: Ministry of Health; PSI: Public Services International.

Acknowledgements

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Educational goals
1. Describe and discuss the forms of gender discrimination that predict workplace violence in Rwanda.
2. Identify ways to use data on workplace violence and gender discrimination to make health systems safer and more equitable for its service providers.

Correspondence

Mrs Constance Newman
IntraHealth International
6340 Quadrangle Drive
27517
Chapel Hill, North Carolina
USA
+ 1 919 313 9100
cnewman@intrahealth.org

Intervening to prevent co-worker violence in US mental health facilities

Paper

Matthew London, Jane Lipscomb, Kate McPhaul
University of Maryland-Baltimore and NYS Public Employees Federation, Albany, USA

Introduction and background

Workplace violence, regardless of the setting and the perpetrator, is an enormous problem worldwide, receiving increasing attention in the U.S. and elsewhere. A significant component of this problem is those actions which are perpetrated by a current or former fellow employee, so-called Type III violence. The problem of Type III violence in healthcare workplaces is of such significance that the principal U.S. hospital accreditation organization, the Joint Commission1, in 2009 issued guidance on "Managing Disruptive Behavior", addressing the impact of this problem on the welfare of both patients and employees.

Our team from the University of Maryland School of Nursing's Work and Health Research Center (WHRC) has received funding from the U.S.'s National Institute for Occupational Safety and Health (NIOSH) to conduct a multi-phase intervention study of Type III violence in a number of state government offices in the Eastern United States. The state in which the work is being conducted has a recently enacted workplace violence prevention law that mandates that all public employers develop a comprehensive program that addresses all aspects of workplace violence, including Type III. Additionally, most state agencies, like their counterparts throughout the U.S., face fiscal pressures and threats of staff reductions.

Methods

Using Participatory Action Research methods, the WHRC researchers convened a Project Advisory Group (PAG) to assist in study design, implementation, and the recruitment of subjects. The PAG included representatives of state agencies and the unions that represent the majority of the workforce. Most of the PAG members also have significant experience dealing with workplace violence.

Phase One of the study involved the use of a questionnaire survey to assess the extent, severity, and impact of Type III violence during the prior six months. The survey began with a six-question modified version of Einarson's Negative Act Questionnaire2. Next, people were asked about their experience with workplace bullying; *"Bullying can be described as having taken place when abusive behavior is repeated over a period of time and when the victim experiences difficulties in defending him or herself in this situation. It is not bullying if the incident does not occur repeatedly."* Finally, we asked whether they had been the recipient of a violent act perpetrated by a fellow employee, defined as having been stalked, pushed, hit, kicked, or threatened with a weapon. Those who reported any of the Type III behaviors were then asked a series of questions: the position within the organization of the perpetrator(s); which actions were taken by the respondent; whether there was an organizational response; and the impact on the respondent. Additionally, all individuals were asked their awareness of relevant policies and practices at their workplace, and their assessment of the overall workplace atmosphere. Finally, individuals were asked a series of demographic questions, though care was taken to protect people's anonymity and confidentiality.

Seven agencies or facilities agreed to participate. Collectively, those agencies represent most major functions provided by state government; administrative, regulatory, and institutional. Three large regionally-based mental health centers were included. Each center includes an adult inpatient facility, outpatient clinics, and community mental health services. One center also operates a youth inpatient facility.

At each participating agency/facility, the WHRC Project Coordinator met with a group of managers and union representatives to plan the administration of the survey. The goals were to maximize participation (response rate), protect respondents' confidentiality and anonymity, and minimize the disruption to the

agency's operation. In most agencies, the majority of employees has a work e-mail account. An introductory e-mail/memorandum was sent to all employees by the management and union representatives. Then each employee received an e-mail from WHRC, describing the project, the survey, and promising confidentiality and anonymity. The WHRC e-mail included a hyperlink that would connect the employee directly to the survey which was housed behind WHRC's university firewall. For those employees without work e-mail access, WHRC provided paper copies of the survey with a stamped envelope in which they could directly return the completed survey to WHRC. Employees were also provided someone from WHRC who they could contact if they had a question or concern. Following the initial solicitation, one- and two-week reminder e-mails were sent.

Phase Two involves working more closely with some of the surveyed organizations to intervene in the problem and to develop a program to prevent Type III behaviors. Two intervention sites were selected based on their interest in developing an intervention program in partnership with WHRC and on their organizational capacity to implement and evaluate the program. Those sites include a large administrative and regulatory agency, and one of the large multi-program mental health centers. At each agency, a facility PAG was formed, including labor and management representatives, to guide their involvement in the project. The initial work of phase two includes: a review of existing policies, practices, and training materials; a review of relevant complaints and grievances; additional analyses of their survey data; and possibly convening focus groups to investigate the issue in depth.

Surveys were analyzed using Stata@, a data analysis and statistical software package. In addition to analyzing all completed surveys, separate analyses were done on employees of the three mental health centers (referred to as "MH") and on the other four agencies (referred to as "NON").

Results

Response Rates
A total of 12,966 completed surveys were received, with an overall response rate of 71.8%. From the three psychiatric centers (MH) that participated, a total of 1,040 completed surveys were received, with an overall response rate of 66.6%. For the other four agencies (NON-MH) that participated, a total of 11,926 completed surveys were received, with an overall response rate of 72.3%.

Demographics
Most MH respondents were women (66.2%), compared with only 47.0% of NON-MH respondents. The majority of respondents from both groups were older than 45 years old (64.1% and 59.4%) and white (88.9% and 85.1%).

Experiencing Negative Acts
More than half (57.5%) of the MH respondents indicated that they had experienced at least one of the negative acts at work, at least once during the prior six months. By comparison, less than half (43.0%) of the NON-MH respondents reported this.

Among the MH respondents, the most common negative acts reported were "been ignored or shunned" (38.8%), "had insulting/offensive remarks made about you" (36.7%), and "been humiliated or ridiculed in connection with your work" (32.5%). These were also the most common acts reported by the NON-MH respondents. In both groups, the differences by gender, race, and age were slight.

In two of the MH facilities, respondents were asked their normal work shift and whether they had worked overtime during the prior month. In none of the other agencies/facilities were these questions asked. Among MH respondents, day shift workers were less likely to report any negative acts than were respondents who worked other shifts (51.8% vs. 61.0%). Those who reported having worked some overtime were more likely to report any negative acts than were those who had worked no overtime (61.3% vs. 43.3%).

Those who reported at least one of the negative acts were asked to identify the organizational position of the person(s) responsible. As respondents could select more than one individual, the sum of the percentages can exceed 100%. For the MH facilities, "co-worker(s)" was said to be responsible for the most bothersome negative act most frequently (56.1%), while "top manager", "immediate supervisor", and "subordinate" were each reported to have been responsible 26-27% of the time. The distribution was similar for the NON-MH facilities.

Experiencing Bullying
Almost one-sixth (16.2%) of the MH respondents reported having been bullied at work during the prior six months. This compares to 9.4% of the NON-MH respondents. Female MH respondents were more likely

than men to report bullying (16.1% vs. 13.9%). Non-white MH staff were more likely to report bullying than were white respondents (17.9% vs. 15.2%). Among NON-MH respondents, the rates did not vary by gender or race. Among respondents from the two MH facilities where work shift and overtime were asked, day shift workers were slightly less likely to report bullying than were those from other shifts (16.6% vs. 18.0%). Those who had worked overtime in the prior month were more likely to have been bullied than were those who had not worked overtime (21.5% vs. 10.0%). Among MH respondents who reported having been bullied, "co-worker(s)" were said to be most frequently responsible for the bullying (45.8%), followed by "immediate supervisor" (37.4%), "top manager" (33.5%), and "subordinate" (19.4%). For NON-MH respondents, the distribution was similar.

Experiencing Physical Violence
Overall, 4.9% of MH respondents reported having experienced co-worker physical violence during the prior six months. This contrasts with 2.5% of the NON-MH respondents. Among both groups of agencies/facilities, men were somewhat more likely to experience these violent acts. Among MH respondents, non-whites were more likely to report these acts than were whites (8.4% vs. 3.7%). This was not the case for NON-MH respondents (2.2% for each racial group).

Younger respondents were more likely to experience these acts. Among the MH surveys, 6.3% of those under 45 years old reported this, compared to 3.2% of older workers. Among NON-MH respondents, 2.9% of the younger workers experienced violence, compared to 1.9% of older workers. Among respondents from the two MH facilities where work shift and overtime were asked, day shift workers were much less likely to report experiencing coworker violence than were those from other shifts (3.7% vs. 10.0%). However, those who had worked overtime in the prior month were more likely to report violence (9.9% vs. 1.7%). Regarding the alleged perpetrator(s), MH respondents were most likely to select "subordinate" (40.0%), followed by "co-worker(s)" (25.0%), "immediate supervisor" (12.5%), and "top manager" (7.5%). NON-MH respondents were most likely to select "co-worker(s)" (49.4%).

Actions taken by Recipient
Those who experienced any of the Type III behaviors were asked what actions they took in response. Among the MH respondents, roughly half (52.8%) "reported it to a supervisor". Most commonly, they "told a colleague" (67.9%), "told friends/family" (61.5%), or "told the person to stop" (39.5%). Additionally, some "reported it to the union" (13.5%), "sought counseling" (7.7%), "charged leave credits" (7.5%) or "transferred to another position or worksite or shift" (4.2%). Only 3.4% "completed an incident/accident report". However, 31.9% "pretend it never happened". NON-MH respondents were somewhat less likely to report the incidents overall.

Impact and Consequences of Most Serious Acts
Experiencing the variety of acts described above impacted employees in many ways. Roughly one-fourth of the MH respondents who reported having experienced the above mentioned acts indicated that it negatively impacted their work (21.7%), their intention to remain in their current job (25.8%), or their personal life (25.8%). The impact was greater on those who were bullied (45.1%, 45.1%, and 47.9% respectively). Interestingly, those who experienced the violent acts seem to have been somewhat less likely to have been negatively impacted (29.3%, 24.4%, and 31.7%). The impact on NON-OMH respondents was similar.

Very few were aware of any consequences for the perpetrator; 5.7% of those who reported negative acts, 7.5% of those who reported having been bullied, and 0% of those who experienced violent acts among the MH respondents. Roughly 2/3 believed that there were no consequences, and the remainder did not know. Very few NON-MH respondents were aware of any consequences, either.

Awareness of Policies and Practices
Most MH respondents agreed that "It has been made very clear to all employees that coworker, supervisor, or subordinate violence and psychological abuse will not be tolerated" (86.1%). A similar majority (87.1%) agreed with the statement "I know exactly to whom I should report coworker, supervisor, or subordinate violence or abuse." For those who reported any negative acts, the percentages were 81.7% and 85.5%. For those who had been bullied, the percentages were 67.4% and 77.8%, while they were 61.0% and 70.7% for those who experienced violent acts. Among NON-MH respondents, the distribution was similar but the percentages were generally lower.

Perception of Work Atmosphere
Among the perceptions of their agency's work atmosphere that were reported, 70.6% of the MH respondents agreed that "Employees are usually treated with respect and fairness by their supervisors", 71.0% agreed that "Employees treat each other with respect and fairness", and 48.6% "Believe the organization as a

whole values and cares about them." For those who reported any negative acts, the percentages were 57.8%, 59.2% and 36.0%, respectively. For those who had been bullied, the percentages were 42.3%, 46.5% and 23.2%, while they were 57.5%, 42.5%, and 22.5% for those who experienced violent acts. Again the results for the NON-MH respondents were similar.

Discussion and conclusions

This study of unionized public sector workers in the US goes a long way toward identifying the extent and severity of Type III conflict and violence in America. Conducted in three state-run psychiatric centers and four administrative and/or regulatory agencies, questionnaire survey response rates were consistently high, averaging 71.8% overall. A total of 12, 966 surveys were completed.

Within the three mental health (MH) facilities, various negative acts and other manifestations of Type III conflict were widespread. More than half (57.5%) reported having experienced during the prior six months at least one of the six negative acts inquired about. Bullying was reported by 16.2%, and actual physical violence by 4.9%. Respondents from the non-MH facilities were less likely to report each of those types of Type III conflict.

While virtually all of the survey respondents faced some risk of Type II violence at work, the MH staff clearly experience much higher levels than do the non-MH workers. This may partially contribute to the higher levels of Type III reported in the MH settings. Closer examination of those data by work unit and bargaining unit confirm that hypothesis.

The survey has proved to be an important tool in convincing managers and union leaders alike of the importance of this issue. During Phase 2 of this project, the research team will be working with a labor-management team in two of the agencies (one MH) to attempt to develop and evaluate a model program for preventing Type III conflict and violence.

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Correspondence

Mr Matthew London
University of Maryland-Baltimore and NYS Public Employees Federation
1168-70 Troy-Schenectady Road
12212
Albany
USA
+1 518 785 1900 ext 348
mlondon@pef.org

Nurses' representation regarding aggression and violence by psychiatric inpatients: The professional experience and formation impacts?

Paper

Didier Camus, Nicolas Kuhne, Béatrice Perrenoud
DP-CHUV Hôpital de Cery, Prilly s/Lausanne, Switzerland

Abstract

Aggressive behaviour and violence are a major concern in psychiatric patients care settings. Although a significant number of studies have been published about the risk factors and their assessment in clinical contexts, violence in psychiatry seems in increase whereas it still remains mostly underestimated by those confronted to it. Furthermore, if many studies have been carried out to know what the nursing staff should do concerning the risk assessment, little has been undertaken to understand what they are really doing in order to evaluate and contain violence in a day-to-day practice.

This is a qualitative, exploratory and descriptive research. The purpose of the study, mandated by the nursing management of the institution, is to describe how nurses and nurse aides working in psychiatric settings identify, and perceive violent behaviour of psychiatric inpatients. Moreover, this study will try to describe nurse's skills, cognitive processes, tools and resources developed to deal with these situations.

Fourteen nurses and nurse assistants have been questioned using semi-structured interviews. They were asked about their perceptions of violence expressed by violence interactions with psychiatric inpatients in the clinical setting. All of the nurses and nurse aides worked in a psychiatric university hospital in Lausanne (Switzerland), in adult or geriatric services. The interviews were tape-recorded and transcribed. Analyses were performed using the analytical framework of Abric.

The results of the analysis show that in spite of the small number of interviews, all forms of violence could be listed. All nurses and nurse aides do condemn "gratuitous" violence, but differences in apprehending this phenomena exist among them regarding the responsibility of mental illness in aggressive interaction. In the eyes of nurses and nurse aides, violence of patient is not the only one to be mentioned. Nurses and nurse aides suffer also from violent behaviour from relatives, colleagues and head nurses. Risk management of the institution is seen as fragmented. Several critics are expressed in the institutional management, especially against the lack of staff and security at given moments. The study noted the importance of the collective dimension of the nursing role for professionals sharing everyday life with patients. At last, the presentation aims to show the last developments in risk management made in practice following this study.

Educational goals
1. To describe the differences on violence representation in psychiatry.
2. To describe the various factors that may explain these representations.
3. To describe the differences on types of violence encountered in the psychiatry hospital context.
4. To describe the violence risk concept developed in our department.

Correspondence

Mr Didier Camus
DP-CHUV Hôpital de Cery
Route de Cery
1008
Prilly s/Lausanne
Switzerland
+41 21 643 63 47
Didier.Camus@chuv.ch

Burnout and violence at Lebanese emergency departments: level, characteristics and determinants

Paper

Mohamad Alameddine, Amin Kazzi, Fadi El-Jardali, Hani Dimassi, Salwa Maalouf
American University of Beirut, Beirut, Lebanon

Background

Workplace violence in healthcare is a serious and invisible occupational hazard that has been on the surge over the last few years (Winstanley & Whittington, 2004; Merecz et al., 2006; Chen et al., 2008; Kamchuchat et al., 2008). Examining and characterizing violence in Emergency departments (EDs) is particularly important since EDs are identified as a setting where health workers are disproportionally exposed to violence compared to their counterparts at other departments of the healthcare facility (Barlow & Rizzo, 1997; Levin et al., 1998; May & Grubbs, 2002; Winstanley & Whittington, 2004). ED employees often work under heightened stress, especially if they work at hospitals located in busy urban centers and/or in situations of war or civil unrests. Although numerous studies have investigated incidents of violence in the ED in developed countries (Fernandes et al., 1999; Jones & Lyneham, 2000; Crilly, Chaboyer & Creedy, 2004; Lau, Magarey & McCutcheon, 2004; Ryan & Maguire, 2006), there is a dearth of studies that systematically examined workers' exposure to violence at EDs in the Middle East region. This study is the first systematic examination to examine the incidence, characteristics and consequence of violent encounters in Lebanese EDs.

There are two main types of violence reported in literature, Verbal abuse (VA) and Physical Violence (PV). A review of the literature revealed that VA is the most frequently encountered type of violence in healthcare settings, followed by PV (Boyle et al., 2007). Depending on the context examined and methodology used, literature reports a wide variation in the incidence of VA and PV in healthcare settings. Irrespective of the study, violence appears to be a significant professional issues that warrant the attention of stakeholders and decision makers, especially that violence is considered as 'part of the job' or 'the daily normal' at many healthcare facilities around the globe (O'connell et al., 2000; May & Grubbs, 2002; Barlow & Rizzo, 2007).

Although, information on workplace violence in healthcare settings in the Middle East region are relatively scarce, the limited available evidence from Kuwait, Iraq and Jordan reveals that exposure to VA and PV is a serious issue that jeopardizes the safety of healthcare workers and affects the quality of patient care provided (Adib et al., 2002; Oweis & Diabat, 2004; AbuAlRub, Khalifa & Bakir Habbib, 2007, Al Sahlawi et al., 1999).

Methodology

A cross-sectional design was utilized to survey all ED workers in six tertiary hospitals in Beirut, Lebanon. The choice of hospitals was based on the advice on an expert panel that identified six hospitals with the high volume of emergency load at Beirut area (one governmental hospital, four private not-for-profit academic medical centers and a private for profit hospital).

The study population included all medical and non-medical workers who get in contact with patients and their families in the EDs, including physicians, nurses, undergraduate and postgraduate medical trainees, receptionists, admitting personnel, cashiers and protection/security officers.

The original survey instrument comprised of five parts that collected information on respondents' demographics, professional background and intention to quit, exposure to verbal and physical violence, outcome of violence, the policies and procedures at place in the hospital, as well as the workers' response to violent incidents. The survey instrument was developed by the research team and was revised, corrected and amended by an expert panel including an ED attending physicians, an ED nurse, a nursing

Faculty member, a health services administration expert and a biostatistician. The final version of the questionnaires and consent form were approved by the Institutional Review Board (IRB) at the American University of Beirut and each of the participating institutions.

Out of a total of 364 questionnaires expected to be returned; 256 questionnaires were collected, yielding an overall response rate of 70.3%. Each of six institutions had an individual response rate that exceeded 60%. Data were entered in the Statistical Package for Social Science (SPSS), version 16.0. Reported information in this manuscript was generated by running frequencies and cross-tabs.

Results

Sample description
Table 1 gives a detailed account of the frequency distribution of personal and professional characteristics of survey respondents. The gender distribution revealed that surveyed ED settings included more male workers, with two thirds of the respondents being males. This could be attributed to the fact that most administrative staff members are males. Survey respondents were also young, with nearly 70% of all respondents aged 35 years or less and 55% of them being single. Furthermore, the majority of the sample had a permanent appointment at the EDs and had been occupying their current position for a period ranging from 1 to 5 years (48 %).

Intention to quit
Intention to quit current position within the three upcoming years was investigated among ED staff. Less than half of the surveyed ED employees (46%) indicated that it is unlikely or highly unlikely for them to leave their jobs within the next 1-3 years. In contrast, more than a third of ED workers (34.6%) indicated that is either likely or highly likely for them to quit their current position at the EDs within the next 1-3 years. An additional 19.4% were undecided. These findings are disconcerting as they constitute an early sign of potential turnover of a considerable proportion of ED employees.

Exposure to and incidence of violence in the last 12 months
Over the last twelve months prior to survey completion, 80.8% (202) and 25.8% (64) of respondents reported exposure to at least one incident of VA and PV; respectively. The most common types of VA reported were loud noises and shouting (66%), followed by angry outbursts (44%), swearing and cursing (31%) and sarcastic/ condescending comments (26%). With respect to PV, the most common types reported by ED staff were pushing, punching and grabbing (39%), punching furniture, equipment and supplies (30%), threatening moves and/or body gestures (19%) and attack with an object (16%). We offer below separate analyses for providers and non-provider, in order to investigate whether they had different experiences with respect to violence.

Among the 192 ED providers who participated in the study, more than three quarters (77.6%) reported exposure to one or more incidence of VA during the past 12 months. Perhaps most worrisome is the high frequency of exposure to VA reported by health providers; with 26.3% of respondents reporting more than 15 episodes and 23.2% reporting 4-15 episodes of VA within the past 12 months.

Table 1: Frequency distribution of demographic and professional characteristics of survey respondents (n=256)

Variable	Values		N (%)
Gender	Male		162 (63.3)
	Female		88 (34.4)
	Missing		6 (2.3)
Age Group	18-25		66 (25.8)
	26-35		112 (43.8)
	36-45		42 (16.4)
	46+		27 (10.5)
	Missing		9 (3.5)
Marital Status	Single		141 (55.1)
	Married		99 (38.7)
	Other		11 (4.3)
	Missing		5 (1.9)
Current position in this ED	Attending physician		18 (7)
	Trainees(1)		68 (26.6)
	Nursing Staff		106 (41.4)
	Administrative Staff		31 (12.1)
	Security Personnel		33 (12.9)
Working Status in this ED	Trainees		70 (27.3)
	Regular Employees	Full time	135 (52.7)
		Part time	21 (8.2)
		Casual	15 (5.9)
	Missing		15 (5.9)

(1)Trainees include undergraduate medical and nursing student as well as fellows, residents and interns.

Among the 64 ED non – providers who participated in the study, 53 (82.8%) reported having been verbally abused within the past 12 months. Nearly half of all non- providers (48.3%) reported experiencing more than 15 episodes of VA within the past 12 months. In terms of physical violence, a quarter of surveyed non-providers reported exposure to PV, with 64.3% of the exposed reporting 1-3 episodes of exposure to PV during the past year. Of all non - providers who reported exposure to PV, 35.7% confirmed that it resulted in an injury to them. The injury was rated as moderate for 21.4% of respondents and minor for 14.3% of respondents.

Consequences of violent incidents among ED staff
Survey respondents specified the negative consequences experienced on their physiological and psychological well being due to their exposure to violence. These consequences varied considerably in terms of seriousness, including: Appetite problems (43%); difficulty sleeping (41%); seeking psychological counseling (33%); considering leaving work at EDs (32%).

Violence instigators in the ED
Survey respondents expressed an assortment of factors that they believe instigate violence in the EDs. Some of these factors related to the administration/management of the EDs while others were relevant to patient characteristics. Factors relating to the way the EDs were administered included: waiting times in the EDs (77.8%), staff attitude (38.3%), lack of effective anti-violence policies (34.4%) and inadequate resources (19%). Other factors related to the characteristics of patients and their families, including: family expectations (50.4%), alcohol abuse (43.8%), drug abuse (37.5%) and mental illness (35.5%).

Discussion and conclusion

This study is the first attempt to systematically examine the prevalence and consequences of violence in Lebanese EDs and is a rare attempt to examine this occupational hazard in the Arab world. It revealed that ED workers are indeed being exposed to high levels of violence, both VA and PV. Study results suggest

that violence, especially VA, appears to be a work environment reality tolerated by workers and managers despite the fact that it has been demonstrated that it could precipitate serious consequences on the workers productivity and well being, as well as on the institution. These consequences should be seriously considered by policy and decision makers, especially in light of the current and future anticipated shortages of human resources in the Middle East region and the high attrition of nurses from the health care market in Lebanon (El-Jardali et al., 2008; El-Jardali et al., 2009).

The fact that less than half of surveyed ED workers expressed likelihood to stay in their current job is quite alarming as it indicates a potential high rate of turnover at surveyed EDs. Although it cannot be ascertained in this study that violence is responsible for this high intention to quit, findings highlight that it is indeed one of the main causes for staff dissatisfaction and sub-sequent turnover.

The findings of this study demonstrate that many of the factors that instigate violence at EDs and subject workers to danger might be amenable to the intervention of the administration and management of the EDs, including: Wait times, Communication training

Violence & aggression largely prevail in the work environment in Lebanese EDs. We call on governments to work collaboratively with ED stakeholders including healthcare institutions, professional bodies and academic institutions in order to formulate, monitor and evaluate the existence and implementation of effective anti-violence policies and procedures in all EDs. Staff training on the use of these policies and measures should also be mandated and evaluated. This concerted effort, in our view, is a prerequisite to establishing a zero-tolerance policy across Lebanese EDs and other countries in the region. While some of the findings and recommendations of this study are only appropriate in the Lebanese context, others will most certainly apply to the context of other Arab countries.

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Educational goals
1. To assess the incidence and describe the types of violence that workers are exposed to in Emergency Department in Lebanese Hospitals
2. To investigate the determinants of violence against Emergency Department workers in Lebanese Hospitals.

Correspondence

Mr Mohamad Alameddine
American University of Beirut
Bliss street
11-0236
Beirut
Lebanon
+96 11 350 000
ma164@aub.edu.lb

Situation and contributing factors of workplace violence among nurses

Paper

Babak Motamedi
Faculty of Nursing, Islamic Azad University, Dehaghan Branch, Dehaghan, Iran

Introduction

All health care professionals including nurses have the right to work in an environment that is free from harassment and threat. This research was conducted in Isfahan, Iran, aiming to explore the situation, contributing factors and management of workplace violence among the nurses. The issue of violence against nurses at work is a serious one which must be addressed urgently. Despite strong measures introduced to combat violence and abuse in the workplace, recent media reports of incidents against nurses show that violence in the workplace continues and recent evidence suggests that the incidence of violence and abuse towards the medical profession remains a real threat.

Method

Total samples of 250 nurses were recruited from all the health care services available in Isfahan, representing all branches of practice. Data were collected between January and March 2007. The research setting in this study is the city of Isfahan in centre part of Iran. In Isfahan, there is a wide variety of health care services, including all the types of services and levels of health care available in Iran.

The subjects were recruited from all health care levels and all professions by cluster random sampling techniques. Health posts/centers, community hospitals, and private hospitals were randomly selected. The specific number of subjects recruited from each health setting was estimated from the number of patient beds available in the setting. Thirty percent were recruited from hospitals equipped with more than 30 beds but less than 100 beds and 15 % from those with more than 100 beds. For small hospitals equipped with less than 30 beds, the number of subjects varied from 5 to 10. If there were no patient beds, the number recruited was approximately 10-15 % of the number of total nurses.

For the quantitative data, the researchers and/or the research assistants contacted the relevant authorities for permission to collect data. The purpose of the research project as well as the techniques and procedures for questionnaire survey were explained. After that the researchers and/or research assistants distributed the questionnaires through accidental random sampling techniques. That is, the nurses who were available and accessible during that period were invited to participate in the study. To reduce biases, the accidental sampling techniques were explained in detail and justified. In the setting where the personnel were difficult to access, a person working there was invited to assist in distributing and collecting questionnaires. The procedures were explained to that person. For small workplaces in remote areas, the questionnaires were distributed and returned by mail.

Nurses were asked a series of questions about their personal experience of workplace violence in addition to their views and perceptions of violence in the workplace more generally. This can include verbal aggression or abuse, threat or harassment as well as physical violence.

For the purposes of this study, the definition of violence follows has been accepted: "Any incident where nurses are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health".

In the qualitative part aiming to verify the definition of workplace violence and other aspects, six groups were included (registered nurses/midwives, technical nurses, practical nurses, nurse aids, and health workers). Data from these groups were mostly obtained through 15 interviews consisting of 90 nurses recruited according to availability. The number of participants in each group varied from 3 to 9. Almost all of the groups consisted of same-sex nurses from the same levels. The time spent in each group interview varied from 60 to 180 minutes. Interviews were stopped when the obtained data became redundant. For the

rest of the groups, data were obtained through formal individual interviews and occasionally informal interviews from 25 persons. A few interviews were conducted via telephone.

Qualitative data were collected through interviews, with audiotape recording if permission was granted. Field-notes were taken as well. Since workplace violence is a sensitive issue, the privacy, confidentiality, and safety of the subjects were protected throughout the processes of qualitative data collection. Most of the individual interviews were conducted at the participants' workplaces. Prior to data collection, the researchers asked for written permission from each workplace. All subjects participating in interviews were requested to give oral consent after the explanation of the research project's objectives, procedures, confidentiality, as well as the benefits and possible risks.

Data Analysis

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

Results

The sample size was 250. Majority of the sample were female (65.7 %) and had up to 5 years' working experience. Most of the samples were single. There were non-significant differences in the age and years of working experience between males and females. More than a half the sample (52%) had reported that they were victimized at least once in the previous year. Verbal abuse, the expression through words or verbal behaviors was found to be the most common type of workplace violence. Qualitative data supported this finding.

Verbal abuse was found to be the most common type of workplace violence. Among hospital nurses, those working in Psychiatry, Drug abuse and Screening units are more likely to report violence as a problem in their workplace. A third of nurses who reported experience of workplace violence experienced physical violence or abuse. These incidents ranged from being kicked, bitten, punched, knifed and hit.

Sexual harassment was the least common type of workplace violence. Females, younger nurses, working in night shifts, having physical contacts with patients, working in crowded units and poor working experience nurses were more likely to experience violence. The subjects with fewer years of working experience were more likely to experience violence, especially verbal abuse, than those with more experience. The personnel whose working experience was less than 5 years experienced violence greater than did the personnel who had over 10years of working experience.

The subjects working in private organizations experienced violence significantly less
than those working in the government health sectors. It was found that the violence incidents were more prevalent among the nurses who reported that there had been a reduction in staff numbers in their workplaces. It was found that there was no statistically significant difference in the experience of each type of violence across marital status, and ethnicity (p > .05). Most respondents who experienced violence or abuse in the last year, reported patients as being the main perpetrators, followed by patient's family and/or relatives. Other perpetrators included managers, other medical staff, nurses and the general public.

The psychological backgrounds of perpetrators, especially of managers and other medical staff are: Lack of emotional and moral maturity and control, anger management skills, stress releasing skills and communication skills, psychological stress caused by working, as well as personal, economic, and family matters. A few subjects suggested that violence was a learned behavior. If noting happened or perpetrators did not receive any punishment for their violent acts, they would repeat them and increase their severity.

Dissatisfaction of service provided includes patients' frustration for long waiting times, refused to admit for treatment or prescribe medications and dissatisfaction with diagnosis or planned treatment was the most frequently stated reason for work place violence. Psychological backgrounds, inability to pay for hospital bill, low social security conditions, the rise in prices due to economical inflation and rapid political changes were the indirect factors.

Around a quarter of nurses said that their experience of violence had affected their work. And less than 2 percent reported that their experience had made them consider changing their career.

Discussion

Improved working systems were recommended in order to reduce conflicts and stress and increase quality of services and patients' satisfactions. This would solve the problems of work-overload and staff insufficiency. Improving the workplace atmosphere and cultivating a non-violence tradition were suggested.

Improved relationships between employers, and or senior and subordinated staffs and staff members was also worth working for, recommended the respondents. Reporting the incidents should be encouraged. Procedures for reporting should be practical and feasible. More importantly, positive attitudes toward reporting must be developed among health personnel.

The procedures for investigation and management, including punishment for perpetrators and support for victims, should be developed in concrete ways. Existing regulations in the Civil Service Act as well as existing labor laws and criminal laws should be applied as punishment guidelines. Health services for both victims and perpetrators are essential. Measures adopted for prevention is another issue. They should include direct measures for violence prevention and control, and measures for reducing contributing factors, as mentioned before. The institution of prevention programs in each health setting should be encouraged and supported. The program target groups should include both male and female staff, especially juniors and those who have few years of working experience.

Conclusions

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

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Educational goals
1. To explore the incidence and situation, of the workplace violence among the nurses in Isfahan, Iran.
2. To evaluate the contributing factors and management of workplace violence among the nurses in Isfahan, Iran.

Correspondence

Mr Babak Motamedi
Faculty of Nursing, Islamic Azad University, Dehaghan Branch
86415-111
Dehaghan
Iran
+98 322262 4051
ba_mot2003@yahoo.com

Horizontal violence

Paper

Milijana Buzanin
University Health Network, Toronto Western Hospital, Toronto, Canada

Abstract

Horizontal violence (HV) in the workplace most commonly takes the form of psychological harassment, which creates hostility between co-workers, but can escalate to physical aggression. This harassment can involve verbal abuse, threats, intimidation, humiliation, excessive criticism, innuendo, exclusion, denial of access to opportunity, disinterest and discouragement (McMillan, 1995; Ferrell, 1997 & 1999; Thomas & Droppleman, 1997; Quine, 1999).

University Health Network (UHN) is a large, tri-site tertiary academic hospital in downtown Toronto, Ontario, Canada, employing approximately 11,000 staff. As with many larger organizations, UHN noted an increase in HV either through actual increase in incidents or a culture that supported increased reporting. As nursing staff represents the largest portion of employees and potentially has the most impact on our philosophy of Patient Centered Care, this research on HV focussed exclusively on nursing.

This research included a literature and professional organizations' position statements on workplace violence reviews, examination of policies already established by UHN, and two separate yet corresponding surveys distributed to nurses and their managers. The staff nurses told us that HV is very much present in this workplace and that it has a large impact on their professional and personal wellbeing. They recounted deeply emotional personal stories of coping with HV, some of which they kept to themselves for years. The most important finding was that the HV went beyond being an interpersonal issue as forty percent of respondents felt that they altered how they provide care to patients due to dealing with HV problems. Contrary to other research, it was not only novice but mid career nurses that appeared to most profoundly impacted by the HV. Furthermore, the surveyed managers identified that they lack the skills to deal with identified HV concerns.

During this research, the occasional disconnect between staff and management was identified. For example, answering the question about absenteeism, nurses stated that they not only missed scheduled shifts on account of HV, but some of them have considered leaving the unit and even the organization. Over sixty percent of their managers, however, stated that they believe that HV has 'little effect' on staff absenteeism.

Considering the strategic drivers of this research and the simplicity of the need to stop horizontal violence because it is the right thing to do, the results were presented in a variety of settings within UHN. Primarily, our senior leadership found the results of the surveys concerning and is providing full support towards continued action that will lead towards a safer work environment for our staff and patients. Currently, a number of the recommendations derived from this project as well as new provincial legislation are being implemented by the organization in order to improve the well-being of the UHN's work environment and safety of our patients.

Educational goals
1. To understand the perceived impact of horizontal violence on staff and patients in a hospital setting.
2. To recognize horizontal violence as a significant component of workplace violence.

Correspondence

Mrs Milijana Buzanin
University Health Network, Toronto Western Hospital
399 Bathurst Street
M5T 2S8
Toronto
Canada
+1 416 603 5800 ext. 2783
milijana.buzanin@uhn.on.ca

Influence of empowerment on new graduate nurses' experiences of bullying and burnout in Ontario Hospitals

Paper

Heather Laschinger, Joan Finegan, Piotr Wilk, Ashley Grau
University of Western Ontario, London, Canada

Abstract

The purpose of this study was to test a model linking new graduate nurses' perceptions of structural empowerment to their experiences of workplace bullying and burnout in Canadian hospital work settings using Kanter's (1993) work empowerment theory. Our hypothesized model predicted that higher levels of structural empowerment (access to information, resources, support and opportunities to learn and grow) would be associated with lower levels of workplace bullying, which in turn would be associated with lower levels of burnout. We tested the model using data from the first wave of a longitudinal study of 415 newly graduated nurses (less than 3 years of experience) in acute care hospitals across Ontario. Variables were measured using the Conditions of Work Effectiveness Questionnaire (Laschinger, Finegan and Shamian, 2001); the Negative Acts Questionnaire-Revised (Einersen and Hoel, 2001) and the Maslach Burnout Inventory-General Survey (Schaufeli and Enzmann, 199 6). Using Einarsen's method for calculating bullying prevalence, 33% of the new graduates were classified as bullied. Bullied new graduates scored significantly higher on emotional exhaustion and cynicism and significantly lower on structural empowerment (p <.05). Fifty percent of new graduates reported severe levels of emotional exhaustion (> 3.0) and 21% reported high levels of cynicism (> 3.0). The final model fit statistics revealed a reasonably adequate fit (χ^2 = 14.9, df =37, IFI = 0.98, CFI = 0.98, RMSEA= .09). Structural empowerment was significantly and negatively related to workplace bullying exposure (ß= -.37), which in turn, was significantly related to all 3 components of burnout (Emotional exhaustion: ß=.41, Cynicism: ß=.28; Efficacy: ß= -.17). The burnout variables followed the theorized pattern of relationships in that emotional exhaustion had a direct effect on cynicism (ß=.51), which in turn, had a direct effect on efficacy (ß=-.34). Empowerment also had a dire ct effect on emotional exhaustion (ß=-25). The results suggest that new graduate nurses' exposure to bullying may be lessened when their work environments provide access to empowering work structures, and that these conditions promote nurses health and well being. Managerial strategies to create work environments that may improve retention of new graduates by discouraging bullying and burnout in the workplace are suggested.

Educational goals
1. To document the prevalence and types of new graduates' experiences of workplace bullying in current nursing workplaces that could inform policy development and workplace interventions to prevent negative and counterproductive workplace behaviour.
2. To understand the longer term effects of bullying/incivility experiences on new graduate nurses' health and well-being and turnover by studying changes over a one year time frame (the first year of practice).

Correspondence

Mrs Heather Laschinger
University of Western Ontario
1151 Richmond Street
N6A 3K7
London
Canada
+1 519 661 2111
hkl@uwo.ca

Healthcare professionals' experiences of workplace bullying: Causes, effects and resistance

Poster

Isil Karatuna, Pinar Tinaz
Kirklareli University, Kirklareli, Turkey

Abstract

Study Objective

Workplace bullying refers to a process where the persistent and systematic offensive behaviour is directed towards an employee by one or more perpetrators in the workplace and the victim finds himself/herself in a vulnerable position to defend against and forced to quit the job, where the colleagues are negatively affected. It can be encountered in every culture and sector, however the health-care sector appears to be particularly at risk. This study reports a qualitative research which aims to explore the perceived causes and effects of the phenomenon and the attempts to deal with it, depending on the experiences of the healthcare professionals.

Methods

Ten in-depth, semi-structured interviews were carried out with the participants who considered themselves as victims and/or witnesses of workplace bullying. Seven of the participants were reached through a questionnaire survey measuring the exposure to workplace bullying in a university hospital in Istanbul in 2008. The remaining three were selected from conversations with personal contacts. Interviews between 45 - 60 minutes duration were taped. Upon transcription and analysis of the tapes, the causes, effects of workplace bullying process and the resistance patterns to cope with it were grouped into categories.

Results

The analysis of the interviews revealed that the workplace bullying process starts with a conflicting environment caused by personal and organisational factors such as 'mismanagement', 'envy' and 'personality of the bully'. The most common reported health and organisational consequences of workplace bullying were determined as 'headaches', 'fatigue', 'hair loss', 'nightmares' 'disappointment', 'decrease in the staff morale', 'hostile work environment' and 'intention to leave'. When the responses to bullying situations were examined, it is found that in the early phases of the process all victims behaved in a passive manner. They either 'remained silent' against the bullying acts or 'ignored' the hostile communication that they had been exposed to and tend to do nothing to stop it.

In the contrary, during the latter phases, with regard to the increased severity and frequency of the bullying acts, the victims started to exhibit active responses to deal with bullying. Frequently exhibited active behaviours were noted as 'confronting the bully', 'complaining to the manager/management', 'talking to the co-workers' and 'resisting collectively. Despite the active resistance, five of the victims quit their job and two had the intention to quit. In other two cases the individual active responses ended the bullying situations. Only in one case, the organisation gave active response and the bully was forced to quit the job.

Educational goals
1. This study in the health sector is a contribution to understanding the causes and consequences of workplace bullying from the perspective of both the victims and the witnesses.
2. The study emphasizes the importance of the individual and the organisational active response in preventing or combating the workplace bullying.

Correspondence

Mrs Isil Karatuna
Kirklareli University
Kepirtepe Mevkii, Luleburgaz
39870
Kirklareli
Turkey
+90 2884 174 996
isilbirik@gmail.com

Student to novice: marginalization and horizontal violence in the context of role transition

Paper

Wendy Fucile
Trent University, Peterborough, Ontario, Canada

Abstract

The transition from student to novice, in the context of professional nursing, is one that has the potential to dramatically affect an individual nurse's overall career trajectory. Data indicates that significant number of novice nurses exit the profession in the early years of their career. While there are no doubt multiple factors involved in this outcome, it does suggest that there may be critical events in that early time period. A two-pronged approach, focused on reducing negative events while at the same time supporting the development of effective interventions for the novice nurse, could have the effect of reducing early attrition from the profession.

Experiences drawn from fourth year nursing students in a Canadian university will inform this discussion of what students witness or experience during independent clinical practice and how that may impede their successful transition from nursing student to novice professional nurse in the work setting.

This presentation integrates learning from two fourth year advanced topics courses, one focused on marginalization of at risk groups and the other focused on transition theory. Working within the theoretical framework of a concept analysis of marginalization, by Vasas, and transition theory as proposed by Meleis et al, this paper will focus specifically on the potential professional and psychological effects of horizontal violence at the transition point from student to novice in a hospital-based context. Building on individual experiences in other transitions may allow students to identify personal approaches that will support their transition from nursing student to novice nurse. Curriculum approaches that identify and support students in preparing to deal with the issue of intra-professional bullying and horizontal violence in the nursing workplace will be reviewed.

Educational goals
1. To share the experience of fourth year nursing students in relation to horizontal violence and marginalization in the clinical setting.
2. To discuss the role of educational programs in shaping curriculum to assist nursing students in preparing strategies for a successful transition from student to novice.

Correspondence

Mrs Wendy Fucile
Trent University
1600 West Bank Drive
K9J 7B8
Peterborough, Ontario
Canada
+1 705 748 1011
wendyfucile@trentu.ca

Addressing nurse-to-nurse bullying to promote nurse retention

Paper

Carol Rocker
University of Phoenix, Phoenix, USA

Bullying among nurses in Canada is a problem that drains nurses of both energy and productivity. The Canadian Bureau of National Affairs, Individual Employee Rights Newsletter (2000) reported that bullying is not related to race or gender; rather it is a symptom of emotional distress. Regularly persons in authority positions appear either to not recognize bullying or to reject this concern (Lewis, 2004; Pearce, 2001). Nurses frequently feel at a loss when it comes to controlling the bullying behavior of other nurses. These feelings of helplessness lead to an increase in absenteeism, stress leave, and resignations, all of which contribute to the nursing shortage and cost the healthcare system millions of dollars each year in employee benefits, retention, and recruitment costs (Bureau of National Affairs, 2000).

The nursing shortage is a major concern in Canada. The Canadian Institute for Health Information (2007) reported that Canada had 252,948 registered nurses employed in 2006; 92% of these were Canadian graduates and 8% were International graduates. The number of nurses graduating in Canada has increased 5.3% from 2000 to 2005 (Canadian Nurses Association, 2008). Still, Shields and Wilkins (2005) stated in "The National Survey Report of Work and Health of Nurses "that the Canadian nursing shortage will only increase. Much of this nursing shortage has its roots in human resource management issues, such as failure to control workplace bullying (Canadian Institute for Health Information, 2007). The purpose of this article is to raise awareness of the challenges associated with workplace bullying among nurses by defining and describing the incidence and origin of workplace bullying; reporting the nature of and consequences of workplace bullying for both victims and witnesses; presenting the Canadian legal response, strategies to support victims, and approaches preventing workplace bullying; and considering the nurse manager's role in addressing workplace bullying.

Definitions of Workplace Bullying

Workplace bullying is difficult to define. This lack of clarity has hindered the efforts of Canadian policy makers who have tried to tackle this subject. Hence, Quebec law and the Canadian Initiatives on Workplace Violence have worked to offer definitions of bullying. Quebec was the first province in Canada to amend its Labor Standards Act by defining workplace bullying. Quebec law refers to workplace bullying as psychological harassment and defines it as: Any vexatious behavior in the form of repeated and hostile or unwanted conduct, verbal comments, actions or gestures that affect an employee's dignity or psychological or physical integrity and that result in a harmful work environment for the employee (Canada Safety Council, 2005). Similarly, the report "Bullying and Intimation" as presented in Canadian Initiatives on Workplace Violence (2007) has stated that workplace bullying "constitutes offensive behavior through vindictive, cruel, malicious or humiliating attempts to undermine an individual or group of employees. These persistently negative attacks are typically unpredictable, irrational and unfair… they happen with great regularity within the workplace" (para.1).

Incidence and Origins of Workplace Bullying

Canadian nurses are not alone when it comes to workplace bullying. Cooper and Swanson (2002) have reported that workplace bullying among nurses is now recognized as a major occupational health problem in United Kingdom (UK), Europe, Australia, and throughout North America. Cooper and Swanson reported that 5% of healthcare workers in Finland have experienced bullying. In a survey of National Health Trust community workers in the UK, 38% of staff reported having experienced bullying and were likely to leave their job as a result, whereas 42% had witnessed the bullying of others (Cooper & Swanson). Chiders (2004) noted in "The Nurses in Hostile Work Environment's 2003 Report" that bullying is very prevalent in hospitals and workplaces across the United States (US) to the extent that 70% of victims leave their job, 33% of these victims leave for health reasons and 37% because of manipulated performance appraisals.

After much study Cooper and Swanson concluded, that workplace bullying is a significant, under-reported, and under-recognized occupational safety and health problem. This section will now discuss the origins of workplace bullying.

The problem of bullying may have its origin in individual, environmental, and/or organizational factors. Individual factors include mental illnesses, female gender workers, and drug and alcohol habits. Environmental factors include poor lighting, lack of safety measures, and working with violent or hostile patients and families. Organizational factors include lack of resources, understaffing due to the nursing shortage, poor workgroup relationships, changes in composition of work groups, low supervisor support, increased workload, downsizing, and organizational restructuring (Cooper & Swanson, 2002; Salin, 2003).

Research completed on nurses in the UK has suggested that bullying behavior among nurses is a learned process (Lewis, 2006). For example, newly employed nurses may observe and embrace the bullying behaviors of other nurses just to fit in, thus contributing to the continuation of bullying behavior. This was evidenced in Lewis' findings related to pain management. Lewis found that some nurses strive for freedom from traditional ways of pain management and question traditional pain management regimes that sedate the patient every four hours, regardless of the patient's perception of their pain. Rather these nurses prefer to allow patients to have input into their pain control needs. This difference of opinion as to the degree of patient control over their pain management sets up an opportunity for inter-professional conflict and cliques which become favorable reference groups to which nurses aspire when looking for acceptance. Lewis has argued that these nursing cliques may become vehicles in which bullies may hide, gain support, and use the organizational bureaucracy to their personal advantage as they find strength in being a member of their chosen clique.

Researchers Chaboyer, Najman, and Dunn (2001) found that Australian nurses continue to be an oppressed group that uses bullying tactics as they interact with each other. Hutchinson, Vickers, Jackson, and Wilkes (2006a) also studied Australian nurses and noted that informal organizational alliances enabled bullies to control work teams using emotional and psychological abuse to enforce bully-defined rules. To illustrate these findings Hutchinson et al. (2006b) cited their qualitative study of 26 nurses who had personal experiences of bullying. This study explored the nurses' perspectives regarding the meaning of bullying, beliefs about bullying, and perceptions of bullying, so as to interrupt the bullying process at both rural and metropolitan Australian hospitals. Hutchinson et al. (2006b) found that nurses worked together to control the team "through ignoring, denying and minimizing bullying; indoctrinating nurses into bullying-defined rules; and structuring those they considered weak" (p. 228). Hutchison reported that the nurses' stories revealed bullying-defined rules on the nursing unit enforced the hierarchical separation of labor with aspects of "militarism, public humiliation, and tactics of exclusion" (p. 228). These narratives revealed that bullying on nursing units is normalized through a "Process of Indoctrination" as the bullying breaks a nurse's physical and psychological strength and confidence. Hutchinson et al. (2006b) maintained this either forces the nurse to resign or accept the bullying rules of survival, and commented that these resignations serve no purpose other than adding to the nursing shortage.

The Nature of Workplace Bullying

Some time ago, when I had taken a new nursing position, I observed, and became concerned about the frequent bullying behaviors I was observing among the nurses. My concern regarding this bullying behavior prompted me to begin journaling about these behaviors, as is my custom when situations puzzle me, in an attempt to better understand what was happening. In reading through my journal entries, I realized these behaviors centered around three main themes: Interactions, Power Disparities, and Actions. The Table describes some of the bullying behaviors I had observed.

Lewis (2006) observed that bullies are fully aware of their actions, although actions such as these are difficult to pinpoint, often occurring behind closed doors. Anthony (2006) and Stevenson, Randle, and Grayling (2006) made similar observations while studying bullying behavior directed towards student nurses. Sometimes students experienced destructive innuendo, criticism and resentment, humiliation in front of others, undervalued efforts, and/or teasing. At other times, they were ignored and frozen out. Although students felt like failures if they did not understand something, they tolerated the bullying so they would fit in.

Consequences of Workplace Bullying

Hutchinson et al. (2006a) documented workplace bullying as lasting from six months to seven years, and reported that nurses targeted by bullies frequently find themselves labeled as stupid or less capable. These

nurses then become the focus of attention while the bully goes unnoticed, making the actions of the bully legitimate because the built-in power structures claimed by the bully serve to normalize the abuse. Salin (2003) observed that large organizations with lots of formality and lengthy decision-making processes make excellent shelters in which bullies may hide and go unrecognized. Meanwhile, the victim, and others, may suffer from isolation, fear, and/or stress-related illnesses, or commit suicide. Each of these possible consequences will be described below.

Isolation

Lewis (2004) conducted in-depth interviews of 10 nurse managers working in the U.K.. National Health Service and found that bullies isolated their victim and created a climate of fear in an attempt to make the injured party feel inadequate. Lewis reported that nurses witnessing this bullying behavior were reluctant to speak out lest doing so result in their own censure. Lewis also observed that nurse managers lacked skills, training, and knowledge of how to deal with bullying events, and those complaints of bullying often went unnoticed by the managers. Lewis also noted that managers had an ambivalent attitude towards policies and procedures addressing bullying in the workplace. This lack of managerial skills and commitment to addressing workplace bullying contributed to unsatisfactory outcomes of bullying cases. Lewis concluded that bullies are highly devious individuals, who are well aware of their actions. Swedlund (2004) also observed the isolation experienced by the victim noting, "What people need to learn about is the complete isolation of bullying.…The whipping boy is hit by people while others just stand around.… The person being bullied sees the whole world against him…He's totally isolated" (para. 5).

Fear of Going to Work

Lutgen-Sandvik, Tracy, and Alberts (2006) reported that a target of bullying often faces work with the thoughts of "impending doom and dread." For example, a bullied nurse often fears going to work and is secretly ashamed of being bullied, but is confused as to how to fight back. Lutgen-Sandvik et al. found that with the passing of each day the bullied nurse retreats into silence while others attack her or his person and workplace reputation. Cooper and Swanson (2002), Patten (2005), and the Workplace Bullying Institute (2003) all noted that self-doubt takes over at this point and stifles the nurse's innovation and initiative, resulting in psychological and occupational impairment.

Stress-Related Illnesses

Victims of bullying may show symptoms of nausea, headache, weight loss, insomnia, anxiety, depression, alcoholism, irritability, loss of libido, self doubt, and Post Traumatic Stress Syndrome (PTSS) (Canadian Initiative on Workplace Violence Website, 2007; Gilmour & Hamlin, 2005; Hoel, Faragher & Cooper, 2004; Jackson, Clare, & Mannix, 2002; Knight, 2004). A study done on healthcare professionals in the UK (Hoel et al.) concluded that one in five people being bullied at work exhibit symptoms of PTSS, such as hyper-arousal, feelings of constant anxiety, over-vigilance, avoidance of traumatizing events, and flashbacks. Other research on nurses in the UK (Patten, 2005) has shown that between one-third and one-half of stress-related-sickness absenteeism results from workplace bullying. Patten found that this stress often results in nurses giving up or having fractured careers with serious implications both personal (loss of financial security) and organizational (loss of a valuable employee).

Suicide

Even more serious than stress-related illnesses is stress-related suicide. Hastie (2007) described one young Australian midwife who had entered nursing in 1995 with enthusiasm, passion, and commitment. This midwife had experienced hostility, criticism, and intimidation in her practice, which eventually lead her to taking her life by asphyxiation. Although this event occurred over ten years ago in Australia, Canada is presently reporting one out of seven adult suicides results from workplace bullying (Workplace Bullying Institute, 2003).

Witnesses of Bullying

Bullying affects not only the victim; but also the witness (Patten, 2005). The witness begins to wonder if she or he is next. Subsequently, self-esteem decreases, erodes, and gives way to depression and anger for nurses who witness bullying. Patten found that this kind of depression and anger could lead nurses' spouse or partner(s) to see a decline in their partner's "thirst for life." Patten reported that divorce, loss of marital affection, and diminished attention to one's children can result from workplace bullying.

Canadian Legal Response Related to Workplace Bullying

International attention to workplace bullying has led Canadian lawmakers to look more fully at bullying and establish laws related to bullying. Lewis and Lawson (2004) have noted the following changes in Canadian laws related to bullying:

- The Canada Labor Code amended its 2000 regulations requiring the employers to take prescribed steps to prevent and protect workers from workplace bullying.
- British Columbia, Alberta, and Saskatchewan amended their Occupational Health and Safety Acts to attend to workplace bullying.
- Ontario gave workers the right to refuse unsafe work; nurses arguing harassment under the Ontario Health and Safety Board may find their case referred to the Human Rights Commission for resolution.
- The Canadian bill C-45 holds corporations, senior officers, and directors criminally liable for reckless endangerment of the safety of staff in the workplace.
- Canadian law now states that nurse victims of workplace bullying who develop mental or physical illness may be entitled to compensation under Workers' Compensation legislation.

However, my personal observation has been that most nurses have only a minimal knowledge of these Canadian Anti-Bullying laws. No specific legislation exists in Manitoba, Yukon, North West Territories, Nunavut, Ontario, New Brunswick, Nova Scotia, Newfoundland or Labrador regarding workplace bullying, but General Duty obligations exist under Occupational Health and Safety Legislation whereby employers must provide a good working environment for its employees (Canadian Initiative on Workplace Violence, 2007).

Strategies to Support Victims of Workplace Bullying

In spite of the fact that bullying is unacceptable and healthcare managers are expected to ensure a respectful work environment for nurses, workplace bullying continues to exist among nurses. An important person in stopping this bullying is the individual involved! However, when these victims of nurse-to-nurse bullying decide they have had enough of "going to war every day," they will need support from within and outside the organization that enables them to maintain a positive attitude within themselves while successfully dealing with workplace bullies (Patten, 2005). The ability of the nurse to stop this bullying can be enhanced by both support and counseling.

Tim Field has developed a support program to strengthen a positive attitude about workplace bullying (Field Foundation, 2005). In 1994 Tim Field, a Customer Services Manager in the UK, suffered a mental breakdown when bullied out of his job. As a result, in January 1996 Field set up the U.K. National Workplace Bullying Advice Line, and in 1998 established a Bully On-Line Website. Before his death in 2006, Field lectured throughout the world and received an honorary doctorate for his initiatives to stamp out worldwide bullying (Bullying On-Line Website, 2005). The Field Foundation remains committed to working for a world free of bullying through activities, research, and education. The Canadian branch of the Field Foundation, the Anti-Workplace Bullying Support Group, located in Vancouver, British Columbia, meets monthly to share information pertaining to bullying laws and regulations in British Columbia and to raise awareness of bullying within the province. The ultimate goal of this group is to facilitate changing attitudes about bullying in the workplace.

Although I found no mention in the literature of any healthcare region in Canada having support groups specifically for nurses experiencing workplace bullying, many healthcare regions throughout Canada do have Employee Assistance Programs that provide counseling. For example, the Vancouver Island Health Authority (VIHA) confidential Employee and Family Assistance Program is a program that nurses can access regarding problems that affect work life and general well-being (VIHA, 2007). Counseling is also available to nurses through their family physician and community mental health services.

Strategies to Prevent Workplace Bullying

The Canadian Initiatives on Workplace Bullying (2005) found a need for nurse leaders to understand the relationship between nurse-to-nurse bullying in the workplace and economic costs associated with nurse resignation. Nursing leaders can play an important role in communicating that bullying behavior will be replaced with respect, while the perpetrators of bullying behavior receive help, thus creating a safe working environment for nurses. This elimination of workplace bullying includes education, policy, and celebration.

Education

The first step in teaching nurses how to decrease bullying by others is to help them understand what to do and what not to do when confronted by a bully. Beech (2000) found that to reverse bullying behavior and keep nurses in the workforce nurses must support one another. Beech noted one of the major mistakes nurses make when confronted by a bully is to try to reason with the bully and help the bully understand their position. However, being nice to a bully only confirms the bully's superior beliefs. Beach found that

the bullying occurs as bullies gather compliant co-workers around them and devise strategies to get rid of those who are less compliant. Beech encourages nurses to never resign, because their resignation would mean that the bully had won. Rather Beech encourages nurses to keep a file of what is happening to them, as they may be required to produce these evidence months in the future.

Nurses are encouraged to become involved in developing anti-bullying programs that teach the principles of bullying avoidance. The Canadian Center for Occupational Health and Safety (2007) has suggested the following content be considered in these programs:
• Definition of workplace bullying
• Legal obligations
• Anti-bullying prevention policies
• Bullying assessment
• Developing preventive measures
• Reporting and investigating.

A formal evaluation of a program, conducted by a third party not directly responsible for the implementation of the program, can provide objective evidence of the effectiveness of the anti-bullying program (Canadian Centre for Occupational Health and Safety, 2007).

Policy
Involving nurses in policy development gives them the opportunity to take ownership and responsibility for the environment in which they work. Enabling nurses themselves to develop a policy addressing workplace bullying is one strategy to decrease bullying. Such a policy should target positive behavior and work towards creating a working climate that treats nurses with dignity, respect, and fairness (Tehrani, 2005). Tehrani states that the aims of an anti-bullying policy should strive to accomplish the following outcomes:
• Ensure the dignity at work of all nurses
• Respect and value differences among nurses
• Make full use of the talents of all the nurses
• Prevent acts of discrimination, exclusion, unfair treatment, and other demeaning behaviors
• Demonstrate a commitment to equal opportunities for all nurses
• Display open and constructive in communication
• Handle conflict with creativity
• Show fair and just behavior when dealing with other nurses
• Become educated about nurse and employer responsibilities
• Develop positive behaviors.

A policy such as this can enhance the self-concept of the workgroup itself, thus strengthening group members to prevent bullying within the group.

Celebration
Celebrating positive, bully-free work environments can also decrease bullying behaviors. Bullying Awareness Week provides an excellent opportunity for nurses to celebrate a positive work environment. Bullying Awareness Week is for adults as well as for schoolchildren. The expectation of the Canadian Psychological Association is that Bullying Awareness Week will raise the awareness of bullying in Canada (Service & Cohen, 2007). National Nurses Week is a yearly celebration in Canada and elsewhere. During this week of celebration, nurses may also learn of opportunities to become leaders, innovators, and pioneers in anti-bullying initiatives (Canadian Nurses Association Website, 2007).

The Nurse Manager's Role in Addressing Workplace Bullying

Nursing shortages for the future have been projected around the world (The Canadian Institute for Health Information, 2006; Fulcher, 2007; Horan, 2007; Stevens, 2002). Stevens, and Pearce (2001), have noted that intimidation of nurses by other nurses in the workforce is exacerbating the nursing shortage. Nurse Managers have an important role to play in preventing and correcting nurse-to-nurse bullying to keep as many nurses as possible in the nursing workforce. Ruggiero (2004) recommended visible participation of nursing leadership in addressing bullying to foster commitment, participation, trust, and open communication with front-line workers. Briles (2003) found that managers who acknowledged and addressed workplace bullying were able to effectively help healthcare organization retain good employees. Nursing leaders can do this by establishing an ombudsperson within the healthcare organization to which nurses can complain without fear of backlash. Nursing leaders can also decrease bullying by promoting teamwork and team building among nurses to promote flexibility, sensitivity to the needs of others, and encouragement of creativity within the group. Teamwork and enhanced productivity is achieved when the

group members have a strong sense of belonging and loyalty to the group and the organization. When implementing strategies to address nurse-to-nurse bullying, nurse managers should endeavor to create a culture of change. The new culture will require an understanding of bullying and its implications and the establishment of guidelines for acceptable work behavior and peer interaction (Field, 2005). Additionally, a Dignity at Work Policy, which includes sections on harassment, discrimination, violence, and bullying, can highlight the employer's commitment to provide workers with employment that is free from acts of bullying and intimidating behavior.

Conclusion

The problem of nurse-to-nurse bullying in the workplace has gained considerable attention as nurse leaders struggle to recruit and retain nursing staff. As role models and creators of the work group culture, nurse leaders play a key role in combating bullying in the workplace. It is not enough to simply help the victims; rather programs and policies need to be developed to address bullying behaviors. Bullying must become unfashionable. Education, policy development, celebration and support encouraged a whole generation of smokers to "butt out". The same efforts must be initiated to stop bullying in the workplace.

Table. Examples of Nurse-to-Nurse Bullying

Communication	Description
Interactions	• Withholding information • Posting documentation errors on bulletin boards for all disciplines to view and others to critique • Intimidating others by threats of disciplinary procedures • Writing critical and abusive letters or notes to co-workers • Verbalizing harsh innuendos and criticism • Using hand gestures to ward off conversation • Rolling eyes in disgust • Having personal values and beliefs undermined
Power Disparities	• Using shift/weekend charge positions to direct/control staff assignments/breaks • Controlling co-workers' behavior by reporting them to their supervisors for perceived lack of productivity and assistances • Placing others under pressure to produce work and meet impossible deadlines • Withholding knowledge of policies and procedures to get co-workers in trouble
Actions	• Yelling at co-workers • Demanding co-workers answer the telephone, NOW! • Refusing to mentor and guide new staff in their practice • Refusing to help those who struggle with the unknown and uncertainty • Refusing to help others in need of assistance • Giving public reminders of incomplete/missed documentation or work

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Correspondence

Mrs Carol Rocker
University of Phoenix
4615E Elwod St.
85040
Phoenix, AZ
United States
+1 800 366 9699
carolrocker@shaw.ca

Perception of violence by patients hospitalized in the medical and surgical services of a public hospital

Poster

Monica Burgos, Tatiana Paravic
Universidad de Concepción, Concepción, Chile

Keywords: Hospital violence, perception of violence, patient hospitalized in the medicine and surgery wards.

Abstract

This is a descriptive, comparative and co-relational study. Its general objective consisted in finding out about hospitalized patients' perception of violence and its related variables in the medicine and surgery wards of a public hospital. The study is based on Chapell and Di Martino's Interactive Model of work-related violence applied to the hospital environment.

The sample was made up of 174 patients; 70 from the medicine ward and 104 from the surgery service. Some of the findings were the following: 35.7% of the patients in the medicine service, and 42.3% of the patients in the surgery ward perceived violence while receiving hospital care. This perception of violence corresponds to younger patients who have a higher educational level. They rate the care received as deficient. Violent behavior was most frequently perceived during night shifts. "Lack of care" and "impersonal treatment" from hospital personnel, were the attitudes most frequently perceived by these patients. They relate excessive work stress imposed on the personnel of the health care system as the main factor accounting for violent behavior.

Correspondence

Mrs Monica Burgos
Universidad de Concepción
Roosvelt esquina Janequeo
Concepción
Chile
+56 41220 70 65
moniburgos@udec.cl

A study of interpersonal conflict in nurses examining the psychological process of compulsively aggressive behavior of nurses

Poster

Naoko Shibuya & Sanae Kayukawa
Chubu University, Kasugai, Japan

A questionnaire was administered to the 1001 nurses who worked at the psychiatric wards, in order to analyze the psychological process and its related factors which arouse anger and led to aggressive behavior. A causal model concerning the relation among the factors was confirmed by the structural equation model (SEM). As a result, the following model was best fitted to the process which led the expression of the aggressive behavior, and the factors which affect the process: a) unable to receive social supports led to b) accumulation of stresses (concerning the human relations and the environments of at the workplace, and the job contents), c) arousal of anger emotions, and d) aggressive behavior, consecutively. The difference between the sexes was found in some factors such as sympathy, by the multiple group analysis (the ratio of men to women was one to three).

Subsequently, the anger experience of the people with schizophrenia and their family's difficulties of communication with their schizophrenic members were investigated by the half-structured interview.

We discuss the promotion of the mental health of the psychiatric nurses by consideration and integration of the findings on both the nurses and the people with schizophrenia.

Educational goals
1. To promote the mental health of the psychiatric nurses by consideration and integration of the findings on both the nurses and the people with mental diseases.

Correspondence

Mrs Naoko Shibuya
Chubu University
Matsumoto-cho
487-8501
Kasugai
Japan
+81 568 51 9603
dcptc036@nexyzbb.ne.jp

A study to understand violence faced by female health workers: A need to develop hospital based response

Poster

Padma Deosthali Deosthali, Sangeeta Rege
Centre for Enquiry into Health and Allied Themes, Mumbai, India

Study objectives

The study was aimed at understating the different forms of violence faced by female health workers at work place as well as in their personal lives. The second objective was to understand the barriers faced by them in accessing the current avenues to redress the issues pertaining to violence faced.

Method

The method employed for the qualitative research was that of Focused group discussions with Female health workers. A FGD guide was developed. Separate groups of female support staff, nurses, Resident medical Officers and Senior medical officers were formed, considering the fact that the Public health system woks with a strong hierarchy, thus rendering it difficult for the subordinate staff to speak freely in the FGD. The FGD's included a representative sample of women from different religions, economic classes as well as years of work experience. The study sites were 2 Public hospitals in Mumbai, India.

Results

It was seen that female health workers across hierarchy, be it support staff, nurses or Doctor reported that they faced abuse from not just the superiors, but also their subordinates. The latter is especially true when it is male subordinates. The nature of abuse ranged from verbal abuse, sexual comments about clothes; to discussing the female anatomy in detail in a sexual manner Most of the respondents stated that they face sexual harassment both from their male colleagues, subordinates as well as from the patients.
Domestic violence was reported again across all the groups of female workers. It ranged from women doctors not being allowed to pursue post graduation by the family to questioning the duty hours and suspecting their characters. All women stated that they faced a lot of emotional abuse due to their night duty hours. It was seen that in spite of the nature of abuse being reported at both levels, most respondents did not seek any formal redressal to address these issue for fear of stigma, lack of support and belief that they have to live with it. Respondents stated that the norm was to speak to a colleague or a friend. Further, none of the hospitals had any formal mechanisms to address issues pertaining to violence faced by female health workers

Learning outcomes

Though women workers face violence both at work place and in their personal lives, it is the fear of stigma, lack of belief in the formal hospital system and impact on their employment that prevents them from seeking redressal. Therefore they have suggested to set up a forum to discuss the issue of violence giving due respect to confidentiality of the individual and information.

Educational goals
1. To bring out the fact that women workers form several forms of abuse at both professional and personal front, however there is almost no documentation of the same in the Indian context.
2. To understand ways and means of developing a response means to address the violence being faced by them.

Correspondence

Mrs Padma Deosthali Deosthali
Centre for Enquiry Into Health and Allied Themes
Aram society road
400055 Mumbai, India
+98 925 979 94. padma.deosthali@gmail.com

Violence among nurse learners: descriptive study examining Student Nurses' experiences in Cape Town, South Africa

Seminar

Tania deVilliers, Doris Deedei Khalil, Patricia Mayers
Faculty of Health Sciences, University of Cape Town, Cape Town, South Africa

Introduction and background

Over the last decade, there has been steady increase in South African newspapers of violence in our society. Violence among nurse learners is a concern because violence at this level could arguably affect the quality of patient care and the image of the profession in general. This study describes perceptions and experiences of violence among nurse learners at a college of nursing in the Western Province of south Africa. The study formed part of a larger study conducted on violence in the nursing profession. The main study examined violence in nursing at three distinct levels, and assessed the extent to which five categories of nurses' resort to specific behaviour patterns towards others. Nurse learners were one of the categories of nurses in the larger study on violence in nursing, and the presence of violence among nurse learners was confirmed.

Aim and objectives

The aim was to explore and describe factors contributing to violence among nurse learners. Objectives were to describe the profile of student nurses at the college, examine their perceptions of violence, and to explore their experiences of violence.

Research design

A descriptive survey was selected to focus the study. Ethical approval to conduct the study was granted in 2008. Non-probability sampling was utilised to select two hundred and twenty-three student nurses from first to fourth year. Five nurse-educators were identified to provide information as key informants.

Methods of data collection

The second section the original questionnaire was modified and distributed to students in the college. Interviews were conducted with students and nurse-educators.

Results

The student nurses confirmed that there is violence among students. They indicated that violence occurs in the forms of violation of other students' property and space, and verbal abuses. Students attributed violence in the college to substance abuse. Students interviewed, expressed anxiety about their learning environment and feelings of helplessness. The nurse-educators supported students view that substance abuse regularly led to vandalism of college and other students' property. The educators also confirmed that there is verbal abuse and threatening behaviour among students, which has created atmosphere of fear and anxiety.

Conclusion

Some recommendations proposed were that the college management should ensure that violence among student is eradicated. Furthermore, violence among students could negatively affect learning and special support should be available for vulnerable students experiencing violence in the college. However, considering the caring nature of nursing, perpetrators of violence in a college of nursing may continue to violate other nurses after completing their training. Therefore, if student nurses are fighting among themselves, what will be the future of the profession?

Educational goals
1. To share with participants types of violence that exist among student nurses in a nursing college in Cape Town.
2. To discuss the effects of violence on students learning.

Correspondence

Mrs Tania deVilliers
Faculty of Health Sciences, University of Cape Town
Private Bag X3, 7935 Observatory, Cape Town
7935
Cape Town
South Africa
+ 27 21 406 6346
tania.tania@uct.ac.za

Lateral aggression among nurses in British Columbia

Paper

Douglas McLaren
Union of Psychiatric Nurses, Coquitlam, B.C., Canada

Introduction

Lateral Aggression is a growing trend in workplaces throughout the world. It is having a profound negative impact on the lives of workers and their families, and the organizations that they work for. It can be shown that workplace aggression has a significant impact on employee health, sick leave, turnover rates, organizational commitment, and productivity (Cheng, 2000; Hutchinson, 2005; Woelfle, 2007; Griffin, 2004; Hoel, 2003). As well, when employees leave a workplace because of these types of negative experiences, they will often pass the message on to others in the field and this can have an adverse influence on recruitment (Jackson, 2002).

Healthcare is no exception to this trend and there have been a wide variety of studies into the problem in New Zealand (Foster, 2004), Australia (Farrell, 1999; Farrell, 1997; Hegney, 2003), and the United Kingdom (Quine, 1999). These studies have revealed that healthcare workers, and especially those in the nursing profession, are particularly open to workplace aggression and are most significantly impacted by lateral aggression (Farrell, 1999).

North America is late in recognizing the extent and effects of workplace bullying while many other countries have been active in increasing public awareness of the issue and its impacts on society as well as providing mechanisms of support and advice for victims and influencing government and community leaders to address the problem (Zapf, Einarsen, Hoel, & Vartia, 2003). They have also drawn attention to the destructive uses of power in modern institutions and promoted relevant research to address the problem.

Defining the Problem

One key problem with studying lateral aggression is the profusion of terms and definitions used when discussing the issue. Bullying is the most commonly used term; however I've chosen lateral aggression because I don't see all incidents as being specifically bullying behaviour. This term has a particularly intentional flavour to it that, I believe, is not always there. At times, a person exhibiting aggressive behaviour is unaware of the impact of their actions.

This also holds true with the term "mobbing" which infers more of a group activity as opposed to individual acts. Harassment, intimidation, and emotional abuse, while clearly being forms of aggression, lack the scope to cover all of the variety of activities that I would see as part of the problem and they also carry the same connotation of willful intent.

Finally, I don't use the term violence because many people have difficulty equating non-physical abuse with violence. "A supervisor would likely not see his repeated 'book-slamming' as a violent act, and employees are not likely to report the behavior for the same reason." (IOMA, 2001: p.12) Lateral aggression may eventually lead to bodily assault or abuse but in most instances is non-physical.

Lateral aggression in nursing consists of a variety of behaviors. It can include unintentional, thoughtless acts as well as purposeful, premeditated, destructive acts meant to harm, intimidate or humiliate another group or individual(s). Lateral aggression can also range from random instances to a pattern of repeated behaviors. Collectively, these behaviors have the effect of creating an environment of hostility. In its extreme form, lateral aggression can manifest itself as bullying. (Sincox, 2008)

Scope of the Problem

As noted in the introduction, lateral aggression is a significant and wide-spread problem that is infecting workplace environments in all industries and countries. A U.S. study found that 37% of Americans have

experienced workplace aggression. Recognizing that witnessing the humiliation and degradation of others can be vicariously traumatizing as well, they also combined the numbers of those who had witnessed acts of aggression with those who had direct experience of it and found that nearly half (49%) of adult Americans are affected by it. This is estimated to mean that more than 71.5 million workers have been affected by workplace aggression. (Workplace Bullying Institute, 2007)

In the healthcare workplace, it can be seen that matters are no better. A national survey of New Zealand's new graduate nurses, the majority on inpatient units, revealed that 31% (n=551) experienced severe incidents of "horizontal violence" from senior staff nurses resulting in loss of confidence and esteem, absenteeism, somatic and psychological symptoms, transfer, or termination. (Haselhuhn, 2005; McKenna, 2003)

In Britain, one study of the National Health Service, found that more than a third of staff (38%) reported experiencing one or more types of bullying in the past year. (Quine, 1999) Again in Britain, a survey with over 4,100 nurses responding, revealed that one in six nurses had been bullied in the last year by a colleague. (Royal College of Nursing, 2002)

While these studies are just a small sampling of the research that is available, it should be noted that there has been very little investigation done in the Canadian or British Columbian context.

Causes of Lateral Aggression

Discussing the causes of lateral aggression in the nursing field is very difficult as there are so many contributing factors. That being said, one cannot possibly deal with the topic without referring to the theory of oppressed groups which is so prevalent in the literature. (Bartholomew, 2006; Duffy, 1995; Thomas, 2009) According to this theory, oppression exists when a powerful and dominant group controls and exploits a less influential group (in this case – nurses). The result is that members of the oppressed group display common behavioral characteristics, typically low self-esteem and self-hatred. This can create a divided and discordant group. Nursing characteristics such as warmth and sensitivity are viewed as less important or negative characteristics when compared with those of medical practitioners who are often seen as the central culture. The result is that nurses often lack autonomy, accountability, and control over their profession. This can often result in displaced and self-destructive aggression within the oppressed group, resulting in infighting and self-criticism. (Woelfle, 2007)

Lateral aggression is also propagated generationally. Nurses, who had to go through bullying behaviour during the course of their career, especially as new nurses, feel that it is part of the culture and that those coming into the profession should be subjected to the same treatment as a method of "earning their stripes". This leads to the phenomenon commonly called "nurses eating their young" (Bartholomew, 2006; Foster, 2004; Hoel, 2007)

When looking at what can make nurses prone to lashing out at others; we have to take into account the high levels of stress caused by excessive workload, higher patient acuity, nursing shortages and organizational and staffing changes. There is ample evidence that this leads to burnout and creates a climate for nurses to abuse other nurses. (OSACH, 2009; Sunderland, 2001) As one nursing student quipped, "I'm sure those midwives didn't start out being all (bitchy) and nasty. I'm sure it's just the pressure of the job." (Hoel, 2007)

Lateral aggression is not just something that is a "nursing issue" that nurses need to deal with or suffer the consequences. It is also a systemic issue that reaches down to the very foundations and structures of healthcare. Certain conditions must exist for workplace aggression to exist. These conditions are that it must be *possible*, *beneficial* and *triggered* (OSACH, 2009). It is the interaction between these conditions that results in aggressive behaviours.

The systemic conditions we refer to rely heavily on certain structures that foster an aggressive work environment and bullying. Enabling structures make aggressive behaviour *possible*. We've already discussed the strong sense of frustration and dissatisfaction with the work environment prevalent within healthcare which creates a milieu that breeds aggressive behaviours.

Other enabling characteristics include a perceived power imbalance between the victim and perpetrator and low perceived costs for the perpetrator. Two factors associated with this are leadership style and organizational culture. Some organizations, even though they have policies for discrimination/harassment, fail to enforce them due to lack of either education in how to do that or time to monitor the behaviours of their staff.

Motivational structures encourage persons to harass others and seem *beneficial*. These conditions stem from largely competitive organizational environments that foster "survival of the fittest" attitudes. Performance evaluations are based on quantitative measures where one may bully another in order to meet their own performance requirements. Reward systems seem to encourage aggressive behaviour and individuals are promoted despite or even because they have bullied others.

In North America, we see a business and popular culture that is strongly influenced by tough, hard-nose role models. We see influential business magazines such as Fortune, running a regular review of "America's Toughest Bosses" where they admire and condone the bullying behaviours of these business leaders. On television, producers find reality stars, like Chef Ramsay on "Hell's Kitchen", to weekly terrorize, intimidate, and verbally abuse contestants vying for employment. While healthcare employers may talk about the importance of human resources and providing a welcoming and friendly environment for their staff, the reality is that many are captive to these "tough boss" models and it shows in their actions.

Finally, precipitating structures are those organizational *triggers* that can precipitate bullying. Downsizing, restructuring and organizational change are constants in the workplace. These processes leave most healthcare workers struggling in a destabilized environment where everyone is afraid for their future. There is a sense that one should not get too comfortable lest they have the rug pulled out from under them. This atmosphere of apprehension creates a fertile field for bullies to operate in.

Nurse Survey Results

Central to this project was a province-wide survey of over 1,100 nurses which was followed up by a series of focus groups providing more in-depth insights into what is happening in B.C. There has been little to no empirical evidence of lateral aggression within British Columbia's healthcare system and it has been easy for employers to turn a blind eye to the problem.

The phone survey took place between July 24 and August 16, 2009. We polled a combination of registered nurses (RNs), registered psychiatric nurses (RPNs) and licensed practical nurses (LPNs). The completed sample sizes with their margin of error at the 95% confidence level were:

n = 506 RNs   (+/-4.4%)
n = 112 RPNs   (+/-8.7%)
n = 500 LPNs   (+/-3.3%)

The primary objectives of the Lateral Aggression survey were to measure the proportion of members who perceive their workplace environment as either positive or negative; the incidence of various forms of nurse to nurse bullying, either experienced directly or witnessed; and the impact of such behaviour on nurses' ability to work. In addition we wanted to gauge member perceptions of the role of employer and union with regard to workplace environment and relationships and to gather member input as to what constitutes a healthy work environment and how their union might contribute to this.

49.9% of all respondents described their work climate negatively while only 44.8% used more positive terms. This may be somewhat misleading though as many of those who had been identified as having come from positive work environments described extreme to moderately negative workplace experiences when questioned further in the focus groups. The most common descriptor used was stressful (30.4%).

Of the total population 91% reported that they had witnessed some form of aggressive behaviour at their worksite during the past five years and 60% had experienced aggressive behaviours firsthand. Of those who had experienced aggressive behaviours firsthand, we asked how often they had been subjected to the behaviour. There were 2,118 reports of experiencing specific behaviours. 58% of the time these behaviours were experienced several times by respondents and 16% many times.

When it comes to who is actually doing the bullying, the sad fact is that much of it is being done by nurses themselves. RNs were pinpointed as the aggressors between 38% and 44% depending on whether we look at those figures from those who witnessed the behaviour or those who experienced it. When we combine this with the two other nursing groups this increases to between 60% and 61% (See Figure 1).

Figure 1
Who's Doing The Bullying?
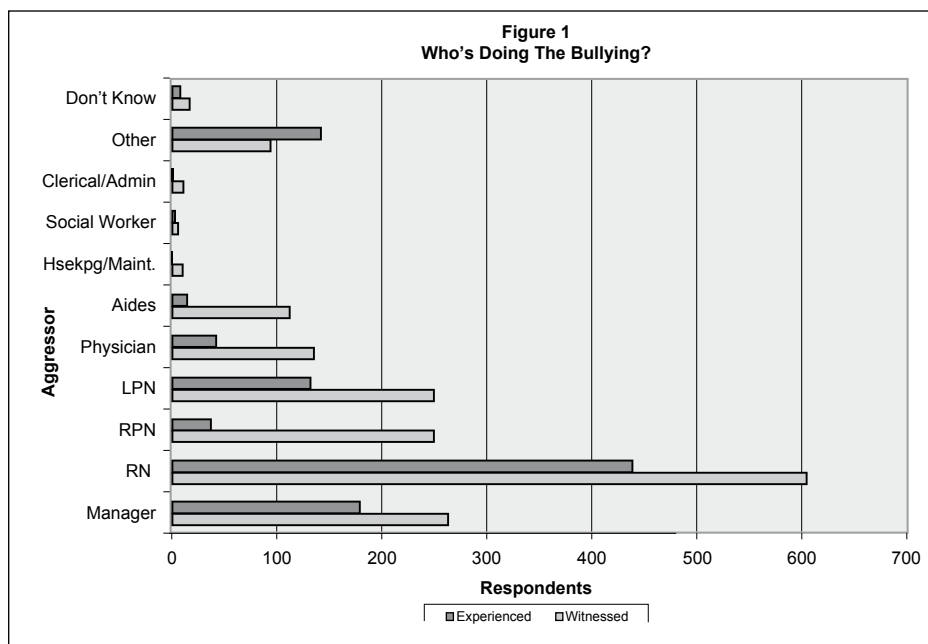
The focus groups had been segregated so that we had an equal number of groups that had identified themselves as working in positive environments and in negative ones. One of the early "ice-breaker" activities with each group was to place a collection of about forty pictures on the table and to ask each participant to select one picture that best described their workplace. Surprisingly, each group had at least one person and sometimes more who chose Edvard Munch's "The Scream" to depict their work atmosphere.

I cannot imagine how difficult it must be to get up in the morning to go to such a workplace. In fact 40% of those who had indicated they had experienced or witnessed lateral aggression (888) indicated that they contemplated not going to work as a result and 12% had missed work because of it. Furthermore, 18% had actually quit their jobs to get away from the toxic atmosphere.

Possible Solutions

This study found a wide variety of possible solutions to this problem. None, in themselves, provides a complete cure but in combination can make a significant improvement. Most important is the need to bring the issue out into the open. Aggressive behaviour flourishes well when no one is paying attention. It is vital that organizations provide education and dialogue on this problem.

A change in organizational culture is also vital if we are to turn things around. We need to move from the old competitive, hierarchic framework and actually encourage collaborative teamwork where individuals are encouraged to be creative without fear of being stepped on.

Finally, we need to rethink the endless spiral of restructuring that is a constant part of healthcare. Do we really need to restructure that much or can we make the existing systems work through cooperation? Where change is necessary, we must provide services to staff that recognize the destabilizing effects of change and how vulnerable it make people to lateral aggression.

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Correspondence

Mr Douglas McLaren
Union of Psychiatric Nurses
200 - 508 Clarke Road
V3J 3X2
Coquitlam, B.C.
Canada
+1 604 931 2471
dmclaren@telus.net

Chapter 9 - Stigma, blame and attribution issues

In and out of control: Healthcare providers' attributions of patients' violence

Paper

Anat Drach-Zahavy, Hadass Goldblatt, Michal Granot, Shmuel Hirshmann
University of Haifa, Haifa, Israel

Objective

In recent years, patients' violence towards healthcare-providers has been so sensationalized by the worldwide media that it has become the vernacular of organizational discourse. Research into violence within the healthcare services shows a rising frequency of incidents over the last decade, with increasing reports of violence directed towards healthcare-providers by patients and their families. Psychiatric services are at particularly high risk, due to unique characteristics of some patients, whose violence is an inherent expression of their mental state. The negative consequences of this violence on healthcare-providers have been well documented in the literature. Yet, only scant research, if any, has examined how differences in providers' perceptions of the violent incident impact their emotional, cognitive, and behavioral reactions towards themselves and their clients. The present study aimed at narrowing this gap. Based on attribution theory, we suggest a typology for depicting healthcare-providers' reaction styles to patients' violence, and how such reactions are related to further treatment of patients, as well as to providers' sense of professionalism.

Methods

In-depth semi-structured interviews were conducted in one Israeli psychiatric hospital with 17 male and female healthcare-providers representing various professional sectors, with varied levels of seniority and professional experience: psychiatrists, nurses, a social-worker, an occupational therapist, and a reception clerk. The interviews were content-analyzed.

Results

We identified four reaction styles:

(1) Violence is in the patients' and providers' control. In this case, providers experience negative feelings accompanied by the perception that they might have been able to prevent the violence. In addition, violence is perceived as part of the job. Therefore, inappropriate handling of the violent incident might harm the provider's sense of professionalism;

(2) Violence is in the patients' but out of the providers' control. Providers experience negative feelings alongside the recognition that they cannot help the patient and perceive themselves as victims. In addition, violence is not perceived as part of the job;

(3) Violence is out of the patients' but in the providers' control. Providers experience empathy accompanied by recognition that they are capable of helping the patient. In addition, violence is perceived as part of the job. Hence, the provider employs proactive steps to calm the patient and prevent the violent incident, which could lead to professional growth. (4) Violence is out of both patients' and the providers' control. Providers experience empathy alongside recognition that they cannot help the patient.

These findings will be discussed in light of attribution theory (Weiner, 1992). Patient violence has an impact on healthcare-providers' professional self-image and sense of professionalism. This might result in an elevated sense of proficiency and skilfulness, in a gradual shift in the meaning of what is professional, or in an experience of powerlessness and incapacity – depending on healthcare-providers' perception of their ability to cope with patients' violence, with obvious consequences for patients' care. Implications for training to cope with patient-violence against healthcare-providers will be discussed, as well as theoretical directions that call for further development.

Educational goals
1. Different attributions of providers' and patients' control ability in the violent incident distinctively impact healthcare-providers' professional self-image and sense of professionalism.
2. These different attributions also distinctively impact healthcare-providers' behavioral reactions towards patients, as well as the quality of care.

Correspondence

Mrs Anat Drach-Zahavy
University of Haifa
Mount Carmel
31905
Haifa
Israel
+972 4 828 8007
anatdz@research.haifa.ac.il

Health care workers becoming victims of violence while healing the victims of violence: Can victims heal the victims?

Paper

Gulsah Seydaoglu, Halide Inci, Cagla Sariturk
Cukurova University, Medical Faculty, Biostatistics Department, Adana, Turkey

Aim

The health care workers becoming victims of violence, however they are healing the victims of abuse and violence. The objectives of this study were to examine the levels and effects of violence in both sides of health sector; the health care workers side who are giving care and the patients' side who are taking care.

Method

A cross sectional study was applied in Adana, Turkey in 2003. Face to face questionnaires were applied to the 244 health care employees working at 4 different urban inner-city secondary care centre in Adana and to the 372 patients who administrated these hospitals.

Results

The mean age of health care workers were 35.9 ±7.6; 63,1% were females, and 37% were midwife and nurse, 31.6% were doctors, 18.0% were assistance personnel and 12.7% were others (such as admitting clerks, etc). A total of 81.1% (n=198) reported have been exposed to violence (38.9% rarely, 44.4% often, 16.7% very often). The ratios were 91.6% for emergency department stuff, 83.1% for surgery department stuff and 66.7% for internal medicine department stuff. A total of 82.3% had been verbally abused, 22.2% recalled physical threats and 15.7% had been physically assaulted.
A logistic regression model was applied to determine the independent risk factors for exposed to violence. Being male (OR: 5.1), being at young age (OR: 31.2), working in unsafe conditions and emergency department (OR: 9.3), being nurse (OR: 5.9 and assistance personnel (OR: 16.9) were found to be independent risk factors for violence.
Of the 12.1% respondents were afraid of patients as a result of violence, 23.7% had reduced job satisfaction, 38.9% feel anger against the patients and almost 1/4 (25.3%) feel alienated from work.
The mean age of patients were 41.1 ±14.3; 48.4% were females, 27.4% were illiterate and 18,3% had no insurance. A total of 55.4% (n=286) reported have been exposed to violence. Of the 10.2% respondents were afraid of health care workers as a result of violence, 52.9% had lost their trust, 76.2% feel anger and 10.7 % feel enmity against the health care workers.
It is a dilemma trying to giving or taking care while both side has been lost their trust and feel alienated against each other.

Educational goals
1. Exposure to violence can cause anger, enmity and alienation and may reflect violence against to the patients or health care workers.
2. Stigma, blame and attribution issues must be evaluated.

Correspondence

Mrs Gulsah Seydaoglu
Cukurova University
Medical Faculty, Biostatistics Dep
01330
Adana
Turkey
+90 533 639 2895
gseyda@cu.edu.tr

Chapter 10 - Strategies and initiatives to manage violence in the health sector at local, institutional, organisational and (inter)national levels, lessons learned

Evolution of a multi-faceted violence prevention and response strategy in public hospitals in New South Wales, Australia

Paper

Judith Kiejda, Trish Butrej
NSW Nurses' Association, Camperdown, Australia

Born of Tragedy

This paper presents an overview of violence prevention and management in NSW public health care facilities and its evolution. The need for a comprehensive strategy was brought to the attention of the public and the government with the murder of a nurse in December 1994 at Walgett Hospital, a small rural facility. A group of men broke into the unit where Sandra Hoare was working alone, kidnapped her, then sexually and physically assaulted and murdered her. As a result of pressure from the NSW Nurses' Association (NSWNA), the NSW Department of Health made an undertaking that nurses would not work alone in isolation. NSWNA also undertook to pursue the following issues as part of the review:
- Increased security staff and patrols,
- Security devices to be installed,
- Improved security for entry points,
- Installation of perimeter fencing,
- Improved lighting,
- Grills for doors and windows,
- Fire exit doors to be alarmed,
- Compounds for vehicles,
- Secure staff quarters.

The New South Wales Department of Health then developed the first security policy and manual with the input of a number of key stakeholders including NSWNA. It was released in 1996 and compliance by public health care facilities was mandated. The Security Manual is divided into three sections. It requires the provision of physical and procedural prevention measures, training of staff, and incident response protocols:
- Part A – Analysing security requirements (e.g. responsibilities, risk management, security surveys, education and training)
- Part B – Dealing with emergencies (e.g. bomb threat; assault, hold-ups and critical incident management)
- Part C – Taking preventive action (e.g. community workers, communication systems, access control, duress alarms, lighting, pharmaceuticals, patients in custody and emergency department security.

The Manual represented:
- A clear performance standard for health services.
- A yardstick against which procedures, equipment, training and the working environment could be assessed.
- A guide to refurbishment and construction.
- An adaptable guide for related services such as private hospitals, residential aged care and disability services.

The Government at that time did not provide any extra funding to support implementation. Implementation was therefore patchy and slow depending on available resources, management commitment, whether there were active NSWNA members at the facility, and whether NSWNA assistance was requested. Running in tandem with the development of the NSW Health Safety and Security Manual was the development of Australian Standard 4885 – 1997 *Security for Health Care Facilities*. While the NSW Health Security Manual has moved forward with time, the Australian Standard has not been reviewed and updated.

The Next Generation

The incident above stemmed from a threat from outside the facility. However, the majority of security and violence risks come from within, e.g. from patients and others legitimately in the facility. This was highlighted when tragedy struck in July 2001 at Kempsey District Hospital, a medium sized rural facility.

A summary of an article from NSWNA's web site describes the event and the subsequent findings of the Court. A psychiatric patient's late-night rampage at Kempsey District Hospital in 2001 cost the life of fellow patient. Repercussions from that night of violence continued when a judge fined the North Coast Area Health Service $150,000. 'T' was admitted to a non-secure psychiatric inpatient ward, after allegedly threatening his wife with a machete and claiming to be God.

Inadequate security measures and inappropriate duress alarm systems had posed a risk of injury to patients and staff. 'T's' belongings were not searched, contrary to the admissions policy. The Health Service admitted that there was no adequate policy, procedure or training to ensure a timely response to duress alarms.

A security report identified failings including:
• *Absence of clearly documented security policies and procedures.*
• *Staff regularly worked alone in isolated parts of the building.*
• *Training in duress response was provided to some but not all staff.*

After this incident, NSWNA approached the New South Wales Government requesting immediate action including the formation of a taskforce, the review and further development of policy, and capital funding to upgrade security. To this end we were largely successful.

A Violence Taskforce was convened and took on a governance role providing advice to the NSW Department of Health and overseeing 5 specific issue working groups:
• data and research,
• education and training,
• security infrastructure,
• clinical issues,
• policy and legal.

It was agreed that an injection of funding was needed. The Government spent a total of $24.5 million on security over a period of 3 years including:
• $7.5 million for capital expenditure for the 2001/2002 financial year
• $5 million for recurrent spending for three years
• $500,000 for training
• Project officer appointed to develop policies and oversee contractors
• Contractor appointed to develop a training program
• Contractor engaged to write information papers and conduct research.

While this sounds like a considerable sum, it represented a relatively small amount on a per-facility or per-employee basis.

The Taskforce agreed that NSW Health needed to embrace a 'zero tolerance' approach. 'Zero tolerance' is taken to mean that violence is not accepted as an intrinsic part of the job, and that action is taken to prevent and minimise the frequency and severity of violence. It was recognised that the range of activities needed to prevent and manage violence was wide ranging including clinical protocols, staffing and skill mix, training, work environment design, provision of security staff and equipment, and the development of security protocols.

The most significant outcomes of the Violence Taskforce and its working groups comprised:
• Funding for capital and recurrent costs to upgrade security (as above)
• A new 'health security assistant' classification that allowed security officers to be employed in jobs that included non-security functions.
• Development of an aggression minimisation training package
• Extensive review of the Security Manual including the development of a mandatory security audit.
• Development of a Zero Tolerance Policy Framework
• Development of design features that facilitate security and their incorporation into facility design guidelines
• Publication of information papers
• Research into health care workers' experience of violence

- Changes to the Crimes Act to make apprehended personal violence orders more effective and to enhance penalties for assault of health employees
- Patient risk assessment tools
- The range of responses to violence available to employees

From a design perspective, it is now common to find the following features:
- Location finding, person-down personal duress alarms
- Staff stations with two exits
- Consultation and examination rooms with two exits
- Secure treatment areas in emergency departments
- CCTV monitoring and recording
- Secure perimeters with door alarms
- Safety glazing
- Quarantined parking spaces for afternoon and night staff
- Security screens at reception counters
- Electronic access to staff-only areas
- Single after-hours entry point.

Prosecutions as Drivers of Management Activity

There have been a number of prosecutions of hospitals and other community services agencies for breaches of occupational health and safety legislation following violent incidents. In many instances, the hazards were foreseeable and known to management, and reasonable action had not been taken to address risks. In almost all instances, significant improvements to safety were made when faced with the prosecution, often so as to more effectively plead contrition before the Court.

All of the Court judgements for the cases listed in the references below can be found on the internet www. austlii.edu.au. Fines ranged from $7,500 to $200,000 with most falling into the $90,000-$150,000 range.

A summary of common deficits identified by the Court include:
- Poor design including lack of escape routes, safe havens, security equipment such as personal duress alarms, and perimeter security
- Lack of procedures for duress response
- Lack of training and information
- No procedures for searching patients for weapons and other hazardous items
- Failure to identify and assess risks
- Failure to take action on known risks, such as replacement of household glass with safety glazing
- Poor lighting.

Over the past few years, the New South Wales Government's policy towards prosecutions under OHS legislation has relaxed, with far fewer prosecutions of government agencies in NSW. The deterrent value of prosecutions in the public sector is therefore diminishing.

Still on the Road – The Current Status of Security Efforts

The security of nurses and patients has come a long way since the mid 1990s. The culture of the health system and the people within it is vital to the implementation of and continuous improvement in strategies for reducing violence and improving the security of patients and staff. It is not until violence as an intrinsic aspect of nursing work is challenged and rejected, that people will turn their minds to possible solutions and strategies.

In New South Wales most nurses and managers no longer find violence an acceptable aspect of work. There is recognition that much can be done through design of workplaces, training, systems of work, clinical practice, and provision of equipment to ensure the safety of staff and patients.

However, the health system is stressed, the demands of the public are increasing and there is a lot of competition for scarce resources. While newer facilities and higher risk areas are well endowed with security measures, many older facilities still lack basic protections, and security and violence continue to be the most common safety issues that members raise with NSWNA. Provision of training is lagging, particularly in rural areas due to lack of trainers and the resources to release nurses from their duties in order to attend training.

Despite the agreement that nurses will not work alone in isolation, many nurses still work alone for at least part of their shift. This typically occurs in small rural facilities and community health services, primarily due to lack of resources. Fortunately nowadays the risk from working alone is moderated through improvements in perimeter security, the provision of personal duress alarms, and the supply of mobile telephones for community nurses.

The requirement for community nurses to be provided with mobile phones is also mandated by the industrial Award covering NSW public sector nurses. In 2009 NSW Department of Health conducted a sample survey of emergency departments and mental health units as being the areas of highest risk. The results revealed a significant deficit in the provision of duress alarms and training in emergency departments although mental health services were well equipped and trained.

The NSW Department of Health is currently reviewing the Protecting People and Property Manual (Security Manual) and associated training. We hope that the policy will be strengthened. The health facility design guidelines which incorporated a significant amount of guidance on security matters, have been recently diluted since the design guidelines project became national, with the guidelines being rewritten in more general terms in order to suit a national perspective.

NSW Nurses' Association continues to respond to members' requests for assistance with addressing security and violence risks. NSWNA conducts inspections, provides reports, and negotiates with employers for improvements. If necessary, a complaint is made to WorkCover NSW, the state's OHS authority, as their inspectors can issue legally binding directives.

We continue to lobby for improvements in security and the prevention and management of violence through working with the NSW Health Department and associated Government agencies to gain funding and improve policies and guidelines around this issue.

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Correspondence

Ms Judith Kiejda
NSW Nurses' Association
43 Australia Street
2050 Camperdown
Australia
+61 2 9550 3667
jkiejda@nswnurses.asn.au

Nurses' experience in caring for incarcerated patients during perinatal care

Paper

Barbara Zust, Lydia Busiahn, Kelly Williamson
Gustavus Adolphus College, Saint Peter, Minnesota, USA

Abstract

The birth of a newborn is a significant life changing event for women all over the world. Studies indicate that psychological support of a mother during labor greatly increases the wellbeing of the mother and the infant. In most American hospitals incarcerated women are not able to have a support person during their birthing process. Therefore, it is important for nurses to provide incarcerated women with the caring support they need. The purpose of this project was to explore the perceptions of nurses' experiences in caring for incarcerated women during childbirth and in the postpartum period.

Following IRB approval, nurses in a community hospital that also served a women's prison, were invited to participate in the study. An 11-item survey required participants to rate their responses about attitude, education, and challenges on a 1-10 Likert Scale and comment on their responses. Data were analyzed using descriptive statistics, simple frequencies, and content analysis of the narrative responses.

Findings

Because incarcerated patients are shackled to their bed, nurses were challenged with their patient's limited mobility. Guards were in the room at all times and were noted to be intrusive, disruptive of the patient's sleep, and occasionally cruel to the patient. Most nurses justified the shackles and cruelty because they felt the patients deserved it.

Some nurses commented that it was too exhausting to work with incarcerated moms who would return to prison, leaving their babies behind, sometimes permanently. A few nurses felt compassion for this time of separation for the mom.

However, many others blamed the mom for her bad choices in causing this pain for the baby. No support for breastfeeding was given to moms returning to prison with a release date in sight. One nurse talked about going outside the institution to advocate for moms to be able to use a breastpump in prison.

Nurses who felt compassion for the incarcerated patient, desired more education in how to best care for incarcerated patients. Other nurses said that they didn't need any more education in how to care for these women and made comments such as "the hospital is already more comfortable than a prison cell; and the incarcerated women could "use this time to think about making better choices in life."

Implications

Nurses need to be prepared to be culturally competent to care for the incarcerated population. More education is needed for nurses to become aware of the harmful potential of their judgment and negative attitude toward incarcerated patients. Judgment about patients leads to discrimination and neglect in caring. Nurses need to see that it is aggression against a vulnerable patient to allow guards to be cruel to a laboring mom, shackled to the bed. Staff needs to have the institutional support of the hospital to intervene when guards are cruel or detrimental to the patient's health. Moms returning to prison without their babies need to be given information and referred to resources for grieving and postpartum depression.

Correspondence

Mrs Barbara Zust
Gustavus Adolphus College
800 W. College Drive
56082
Saint Peter, Minnesota
USA
+01 507 933 8000
bzust@gac.edu

Utilizing a TeamSTEPPS approach to Increase patient and staff safety

Paper

Marlene Nadler-Moodie
Sharp Mesa Vista Hospital, San Diego, California, United States

Abstract

TeamSTEPPS is a process improvement model utilized by a large healthcare organization, in multiple venues, which incorporates strategies and tools to enhance performance of staff and patient safety. Interdisciplinary teams of staff members attend a two day workshop that concludes with action items, an implementation plan and a sustainment plan.

One psychiatric hospital sent two teams from the intensive care unit and the child and adolescent unit to TeamSTEPPS training under the leadership of a Clinical Nurse Specialist. The aim was to identify strategies to reduce restraints or seclusion while maintaining a safe environment for both patients and staff.

Three specific interventions were identified: use of a SAFETY HUDDLE for problem solving, incorporating an END OF SHIFT DEBRIEF into the workflow and instituting interdisciplinary SAFETY COMMITTEES on each unit.

Clinical outcomes are monitored through tracking and trending of the number of restraints and seclusions, number of patient injuries and number of staff injuries related to aggressive management of patients.

Correspondence

Ms Marlene Nadler-Moodie
Sharp Mesa Vista Hospital
7850 Vista Hill Avenue
92123 San Diego, California
United States
+1 858 836-8404
moodienurse@yahoo.com

When restraint is the only option: A safe and compassionate nursing intervention

Paper

Lois Biggin Moylan
Molloy College, Rockville Centre, New York, United States

Background

In spite of the many advances in psychiatry, violence in acute care settings continues and has been reported to be increasing in frequency and severity (Duxbury & Wittington, 2005; Paterson & Duxbury, 2007; Tucker, 2003). This is particularly problematic in view of the desire of mental health professionals to attain the goal of a restraint free environment. Respecting the inherent worth, dignity and autonomy of the patient is necessary if a therapeutic outcome is to be achieved; however protecting the safety of the patient, other patients and the caregivers is of no less importance. This responsibility carries with it legal and ethical implications. Balancing these two responsibilities can be realized even in a situation where supportive therapeutic interventions have been ineffective in de-escalation of an aggressive patient. Interventions that combine safe physical procedures and address the psychosocial and emotional needs of an out-of-control patient are possible, resulting in the maintenance of safety as well as achieving a therapeutic outcome.

Prior to the Restraining Procedure

In all situations of escalating patient aggression, therapeutic interventions should be the least restrictive supportive approaches required to successfully de-escalate the behavior of the patient. If situational or external causes of aggression are identifiable, these should be ameliorated if possible. All psychiatric staff must be trained to avoid behaviors that might provoke aggressive behavior in a patient such as treating them with disrespect or making unnecessary demands upon them. In most volatile situations, a compassionate, therapeutic approach based on theories of communication and psychiatry will be effective. However, circumstances arise in acute care psychiatry when even the best attempts to de-escalate a violent situation are ineffective and physical restraint is the only option remaining to protect the patient and others from serious injury. Legal and ethical standards need to be observed. If the decision to restrain is made too early in the progression of aggression, before attempting other less restrictive therapeutic interventions, it is not legally (Simon and Shuman ,2007)or ethically appropriate (ANA Code, 2005). If the decision to restrain is made too late, assault and injury may result with accompanying legal consequences. Slovenko, (2006) reports that "a hospital (or staff member) may be held liable for malpractice for failure to exercise due care in preventing assault upon a patient" (p255).

All staff working in an acute care psychiatric setting need intensive orientation to the policies and procedures related to restraint use as well as training which includes actual practice of the techniques. Nurses need specific education and direction in assessing the appropriate interventions for the different levels of aggression as identified by the experts in the field and by previous studies. It is important to realize that when violent aggressive behaviors erupt on a unit, the emotions of all nearby will escalate. In staff and patients alike, emotions such as fear and anger may be engendered (Moylan, 1996). Complete familiarity with policies and procedures related to patient aggression will help staff respond professionally and appropriately in these circumstances. Seclusion may be an option, but it is not appropriate if patient safety cannot be maintained by this intervention. Behaviors such as forceful head banging or self-mutilation require more restrictive measures.

The Restraining Procedure

Maintenance of Physical Safety

To ensure the physical safety of all involved, a written policy with specific instructions, based on evidence from studies and history, needs to be developed. There are in existence models of specific restraint procedures. Keltner, Schwecke & Bostrom (2007), in their textbook of Psychiatric Nursing, recommend that staff participate in the restraining procedure provide for support of each of the patients limbs, chest and head. During the procedure no pressure may be applied to vital organs or ribs.   After   the   initial

restraining process of the aggressive patient has been accomplished, the nurse needs to provide compassionate and intensive care of the patient related to vital sign assessment, preservation of circulation, skin integrity, hydration and elimination. Provision of privacy is also necessary. In most institutions the monitoring of the restrained patient's physical status and requirements such as doctor's orders for restraints and length of time in restraints are set by policy which reflects legal and professional standards. The care of the restrained patient is included in most psychiatric nursing textbooks but these generally emphasize the physical interventions (Winship, 2006). In most textbooks used in academic nursing programs, discussion of restraints is often limited to a few paragraphs. Although these texts may mention supportive care and comfort measures, there is very little discussion of related theory or specific interventions aimed at achieving a therapeutic effect, which can be perceived as such by the patient. This consideration brings us to the second goal identified above which is the preservation of dignity, the unconditional positive regard and valuing of the patient as a fellow human being.

Maintenance of the Patient's Psychosocial Integrity

It is not difficult to identify the tremendous emotional stress that a patient is experiencing that brings him or her to the point of total loss of control resulting in unbridled aggression. There are a variety of potential predisposing factors for violence related to the specific patient's psychopathology. Among these are paranoid delusions, effects of psychoactive substances (Duxbury 2005) such as amphetamine or steroid abuse, mania, lack of impulse control or frightening hallucinations (Fagan-Pryor et al., 2003). The patient may also be frightened by his or her own feelings of being out of control and it is not uncommon for patients to verbalize this after an aggressive episode. Therefore it is of utmost importance that the nurse approaches the restraining situation with extreme sensitivity, providing a caring compassionate presence. Only in this way can such a traumatic event result in a therapeutic outcome for the patient.

In order to achieve these desired therapeutic outcomes, nurses need not only training related to the mechanical aspects of restraining but in depth preparation and education concerning the affective components of the procedure. I believe that this can be best achieved by applying the concept of "presencing" as it has recently been discussed in the nursing literature. "The practice of a caring presence can be defined as the intentional authentic responsiveness of the nurse to another human being. The nurse is sincere and expresses genuine caring feelings" (Zerwekh, 2006 p 125). Patricia Benner, the noted nurse theorist, has written widely about this aspect of nursing in classic as well as current works (Benner & Wrubel, 1989, Benner, 2004). She describes how "presencing" is more than being present and that the nurse's actions including body language, touch, tone of voice and showing that the patient has really been listened to have a major therapeutic effect.

The concept of "presencing" is supported by the philosophy of Martin Buber (Birnbaum, 1998), who first explained the relationship between individuals where an imbalance of power may exist. Buber's work was ground breaking in its potential for its application to social and human sciences. This philosophy addresses the primacy of the "I" – "Thou" relationship instead of the "I" – "It" relationship and the implications this had for the disciplines of psychology, sociology and education. Buber (1956), in discussing the "I-Thou" relationship, states "and so he can be effective, helping, healing educating, raising up" (p. 48) This primacy of the "I"- "Thou" relationship takes on even more importance in nursing situations where patients can be highly vulnerable and empathy on the part of the nurse is necessary if a therapeutic effect is to be achieved. It is evident that Buber's concepts are the basis for "presencing", bringing an awareness of the shared humanity between the caregiver and the care receiver where the nurse is able to achieve a therapeutic use of self. This awareness of shared humanity is of utmost importance when it is necessary to employ physical restraint as a last resort for the maintenance of safety in the clinical setting.

During the placement of the patient in restraints, the nurse should supervise the actions of the team making sure that no excessive force is used and the procedure is followed correctly. There should not be unnecessary discussion or comments by the team members and the nurse should, in a calm and even voice, assure the patient of his or her safety. The nurse's words and body language should convey that this is not a punishment. When the patient is secured the nurse should assure the patient that she or he will remain with him or her. The nurse should convey concern for the patient's physical and emotional well being in both words and actions. The restraining process is physically rigorous for the patient and therefore he or she should be offered a sponging with a cool washcloth. Gentle massage of extremities can also be calming if the patient is accepting of this. Offering frequent sips or drinks of fluids also may have a calming effect. Allowing the patient a choice of fluids and the option to have mellow music in the room can give him or her a small sense of control. The patient should be informed honestly and matter-of-factly what behavioral standards he or she will have to meet in order to be released from restraints. The patient should be told that the length of time he or she will need to be maintained in restraints depends on his or her response and that the staff will be glad to help him or her in any way they can to return to regular activities. These caring interventions will

demonstrate the nurse's concern and respect for the patient and the fact that she or he is truly present to the patient in their shared humanity.

Ethical Implications

The subject of physical restraint in acute care psychiatry is indeed a controversial one. Some professionals in this field question whether restraints can ever be therapeutic (Huckshorn, 2004) or if there is ever a legitimate reason for their use (Gordon et al., 1999). As an advanced practice nurse, researcher and academic with more than twenty years in the field of acute care psychiatry, I am in complete opposition to the idea that restraint can never be ethically indicated or that a therapeutic effect cannot be achieved. When a humanistic approach is employed, the safety of the patient and others can be maintained while providing dignity and respect for the patient resulting in a safe and therapeutic outcome.

Aggression by patients in an acute care psychiatric unit may be manifested in various ways. In some cases, patients engage in self-directed harm and actions of self-mutilation as serious as enucleation (Karpinsky, 2003; Kumar & Geist, 2007). Suicides by psychiatric patients have also been reported (Bowers, Simpson, Eyers et al (2006). Patients may also assault others in the vicinity. In an ongoing study conducted by this author in 5 psychiatric settings, more than 89% of the 110 nurse subjects have been assaulted. Injuries reported include bone fractures and permanent disability. From these reports in the literature and research findings, it is evident that restraint may be necessary, when all less restrictive therapeutic interventions have been ineffective, to protect the patient or others. Restraint, as a last resort, is congruent with the requirements of the Code of Ethics for Nurses (ANA, 2005) which requires that the nurse protect the patient from harm as well as maintaining his or her own safety.

Achieving a Therapeutic Outcome

The idea that restraint can never be therapeutic also needs further examination. The literature identifies positive perceptions of restraint by patients when they have felt totally out of control and needed protection. In a study conducted by Wynn (2004), some patients described negative perceptions of restraint while others voiced positive feelings. These feelings included a perception of a calming effect and a belief that the "use of restraint did protect them from hurting themselves or others" (p 136). ". Feldberg (1994), in a study of 69 psychiatric patients hospitalized in a hospital affiliated with Massachusettes General Hospital, also found positive perceptions in a study of patients who had been physically restrained or secluded. Fifty seven of these patients had been placed in four point restraint. Although a majority reported some negative perceptions, 49.7% reported feeling helped by the restraining event. Positive perceptions included feelings of safety, protection and control of impulses. In my clinical practice, patients have verbalized positive feelings of achieving a sense of safety after the restraints had been applied.

In a research study reported by Chien, Chan, Lam & Cam (2005), thirty psychiatric patients in a Hong Kong hospital were questioned two days after a physical restraining experience. Although negative perceptions of the restraining event were reported, two-thirds of respondents reported positive feelings of the restraining intervention relating to achieving a sense of protection and to the caring attitudes and caring behaviors demonstrated by the staff. This qualitative study identified themes of safety and trust; caring and concern of staff; explanation and frequent interaction by staff and being respected by staff. Negative effects reported by patients in this study related to staff who were not empathic, did not seem concerned, did not actively listen to them or did not give information about the restraint during or after its use. This finding provides support for the therapeutic effect of "presencing" where positive response to a restraining experience was related to compassionate treatment of a caregiver.

Conclusion

In an effort to meet the needs of patients and health care workers, rigorous intensive education and training related to the safe, appropriate and therapeutic use of physical restraining procedures must be instituted in acute care psychiatric settings. In this way, safe, compassionate and therapeutic care can be provided to a vulnerable patient population without compromising the safety of health care workers.

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Correspondence

Mrs Lois Biggin Moylan
Molloy College
1000 Hempstead Ave
11571-5002
Rockville Centre, New York
USA
+1 516 678 5000 ext 6867
Lmoylan@Molloy.edu

Creating a safe working environment for staff through the development of Advanced Conflict Resolution Skills: A multidisciplinary approach

Poster

Diane Hickford, Ruth Brown, Russell Sheldrick, Dee Ragou, Sarah Bridgford, Jackie Goodall, Ann Fletcher
Salford Royal Hospitals NHS Foundation Trust, Salford, Manchester, United Kingdom

Abstract

Health care workers face a variety of workplace challenges on a day to day basis some of which can be dealing with violent and aggressive situations from patients, visitors and other colleagues. As health care workers there is also a responsibility and indeed a duty of care to deal with such situations in a safe and responsible manner. Violent and aggressive episodes in the NHS are on the increase (NAO: 2003). Indeed figures from the Unison Scottish Office revealed that 9.5% of all NHS staff in Scotland had had to take time off because they had been the victims of violence and aggression (Unison: 2007) A scoping exercise undertaken in 2004 across the Trust identified that while all areas within the Trust experienced violent and aggressive episode there were certain hotspot areas, these were identified as Ward H2, Emergency Medicine and Neurosciences.

In December 2008 a new course commenced in the Trust aimed at providing staff - initially in the hotspot areas with the skills to:
1. Recognise and safely respond to disruptive and challenging behaviour before a crisis incident occurs.
2. If the behaviour does escalate to violence having the critical skills to be able to professionally deal with the situation and to maintain the safety of all involved.

The course is delivered by a variety of senior staff within the Trust including the Alcohol Specialist Nurse, Clinical Psychologist, Matron, Ward Managers and Practice Development Nurses. The course includes the following topics:
1. Definition of violence and aggression
2. Communication models
3. Warning and danger signs
4. Impact factors
5. Physiological effects of violence and aggression
6. De-escalation techniques
7. The effects of alcohol
8. Trust policy and the law
9. Assessment and prevention
10. Breakaway techniques and debriefing.

A separate bespoke training day is also being developed for Matrons and Lead Nurses focusing on how they can support and debrief staff in clinical practice. A red and yellow card system has been developed to protect staff and control violent and aggressive patients and relatives.

The course will be evaluated in the following way:
1. Feedback via evaluation forms on the day
2. Trend analysis of adverse incident forms pre and post course
3. Staff questionnaire post course.
4. Focus groups

It is envisaged that by November 2010 a full evaluation report of the training will be produced.

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Correspondence

Mrs Diane Hickford
Salford Royal Hospitals NHS Foundation Trust
Stott Lane
M68HD Salford, Manchester
England
+44 1612061561
Diane.Hickford@srft.nhs.uk

Developing and delivering an National Accreditation of Restrictive Physical Interventions Training (Restraint)

Paper

Sharon Paley
British Institute of Learning Disabilities BILD, Kidderminster, United Kingdom

Introduction

The British Institute of Learning Disabilities (BILD) manages the delivery of the only National accreditation programme that accredits training in restrictive physical skills (restraint) in health, education and social care settings in the UK. It is underpinned by national departmental guidance.

In 2002 BILD published the Code of Practice; this is a set of standards for the delivery of training in restraint in services for children, young people and adults who have learning disabilities, autism and emotional difficulties. The standards for accreditation are based on this publication. In February 2010 the code of Practice was updated, this is the third edition having been revised in 2006 to include mainstream school settings.

The use of restrictive practices to manage behaviour has long been a controversial issue; this scheme operates from a values base of respecting human rights and aims to reduce the use of restrictive practices by encouraging the development of training that places and emphasis on developing staff skills and reduce the use of restrictive practices.

Objectives

The aims of this paper are to:
- present the history of the scheme
- explain how training organisations programmes are assessed and accredited
- discuss the achievements of the scheme and impact on training organisations
- highlight significant difficulties in accrediting programmes of training that include physical skills/restraint techniques

Discussion

It is possible to suggest that approaches to challenging behaviour can be split into two distinct categories, firstly those that achieve short term control over challenging behaviour and the development of adaptive functionally equivalent behaviours in the longer term. The second category, are behaviour management strategies that focus on recognising triggers and defusing behaviour whenever possible. Reactive management strategies also include reactive restrictive physical interventions (restraint), when the risk is significant.

People with intellectual disabilities who challenge services are at high risk of being exposed to the use of restrictive physical interventions (restraint) (Emerson 1995, Sturmey 1999, Baker 2000). There is also widespread concern related to the abuse of people with intellectual disability and the use of restrictive practices, including chemical restraint, seclusion, mechanical restraint and policies that infringe basic human rights, this has been highlighted by investigations undertaken by the Healthcare Commission in England (2006, 2007). There have been a number of deaths associated with the use of restraint; Paterson et al (2009) highlighted 22 such deaths that have occurred in the UK since 1979, within health or social care settings.

In 1996 the British Institute of Learning Disabilities published Physical Interventions: a policy framework, Harris et al (1996). This was a seminal publication, being used by a large number of providers in the sector who were 'positive' about the usefulness of the publication, Murphy et al (2003). The publication was

welcomed by professionals working in the field who had struggled with practice issue related to the use of aversive practices, the aim of the publication was to highlight practice issues related to the use of restrictive physical interventions and start to create a framework for professionals to use. This work lead to BILD developing a national reputation as leader in the field in relation to the use of aversive practice within health and social care in the UK, with reference to people with intellectual disability and autism.

In 2002 BILD lunched an accreditation scheme to accredit training in restrictive practices (restraint), the development of the scheme was grant funded by two government departments, Department of Health and the Department for Education. The scheme was underpinned by a Code of Practice (2001) and non statutory guidance (2002). This is the first, and at this time only, national accreditation scheme in the UK operating within health and social care the specifically assesses the standards of training in restrictive physical interventions. The primary aims of the scheme were to:
- Develop a common set of standards for training in the field of physical interventions
- Provide consistency in training available
- Increase standards within the training available
- Support the development of appropriate training
- Support the development of appropriate policy frameworks
- Support care providers to purchase the most appropriate training, ensure training matches assessed need.

Since the launch in 2002 the scheme has continued to assess and accredit training, at the time of writing 30 training organisations are accredited and a further 6 have applied for accreditation in the next quarter of 2010. The scheme has continued to be revised and in early 2010 a new set of standards were published as the BILD Code of Practice for the use and reduction of restrictive interventions.

Conclusions

When the accreditation scheme first launched approximately 1 in 3 training organisations would fail to demonstrate the evidence of, meeting the criteria to be awarded accreditation. With the exception of two organisations all of the organisations that failed to be accredited went on to resubmit an application and receive successful accreditation.

As the scheme has evolved developed the number of organisations that gain accreditation on the first application has increased, it is believed this has occurred mainly due to a change in the scheme and due to rise in standards applied by commissioners of training.

Increasingly commissioners of training appear to be using the BILD Accreditation process as a benchmark for standardising training that is commissioned, it is also the case that some government bodies with a role for inspecting services request that training in physical interventions is accredited by BILD. Therefore there is evidence that a common set of standards may have emerged as a result of the scheme, however there is still some difference between organisations that deliver training and the extent to which they adhere to the principles of the Code of Practice (2010). There is some evidence of standards rising as a result of the scheme and organisations reviewing and changing the content of the training. This has included the removal of some aversive physical skills from some training programmes: the accreditation scheme does not support the training of techniques that are designed to inflict pain or discomfort in order that they are effective.

As the scheme has developed standards have increasingly expected organisations to evidence a good understanding of the needs of organisations based on organisational risk and the needs of people that use the services ensuring training is 'fit for purpose' and appropriate for the environment in which it will be used. In turn this will support care providers to purchase the most appropriate training and ensure training matches assessed need.

In terms of driving change in the field, there is a feeling that the accreditation process has highlighted the need to develop non aversive approaches to supporting, preventing and managing challenging behaviour. However it may also have inadvertently given a message that as long as 'we restrain better' or 'to a certain standard' then any restraint is OK.

In 2009 BILD launched a restraint reduction message. This was supported initially by a mission statement which can be found at the BILD website www.bild.org.uk. In 2010 the first International Positive Behaviour Support Conference was held in Dublin, attended by over 180 delegates from the UK, Australia, Eire, USA and Europe this promoted alternative approaches and non aversive strategies of support for people with intellectual disabilities and autism. In 2011 we will be publishing a review of the literature on restraint

reduction this will form the basis of some research that will evaluate how to reduce restrictive practices in services for people with intellectual disabilities and autism.

BILD believes the principles can as easily be introduced to a wide range of human services, not just those that support people with intellectual disabilities and autism.

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Correspondence

Mrs Sharon Paley
British Institute of Learning Disabilities BILD
Green Street
DY10 1JL Kidderminster
United Kingdom
+44 1562 723025
sharonpaley@sharonpaley.co.uk

'It happens anyway': A trauma response model for dealing with the consequences of violence and aggression in low and medium secure mental hospitals

Paper

Annette Greenwood, Carol Rooney
St Andrews Healthcare, Northampton, United Kingdom

Paper

This paper describes the organisational development of a Trauma Response service for staff working in low and medium secure hospitals. The specialist mental health hospitals have a national reputation for caring for a number of high risks aggressive and violent patients. A starting point for the service was the appointment in March 2009 of a Trauma Advisor to lead and develop a service that takes account of the staff's and the organisational need. This commitment by the organisation to acknowledge the need for staff support and to provide resources for the development of the service were the key factors in the success for both the individuals and organisational needs.

A scoping exercise of over 400 staff was an important part of identifying the design and implementation of the new Trauma Response service. Historically the response had been ad hoc, with no follow up or service evaluation. Staff reported that 'It happens anyway', but we do need something.

The paper sets out the psychological framework that considers recent government reports; NHS Health and Wellbeing (2009) and Improving Health and Work: changing lives (2008) and draws upon the NICE guidelines for support people who have experienced a traumatic event. The model builds upon the latest directives and research that seems to suggest that work is good for your mental health and an early return to work helps to build resilience and personal growth. One of the main challenges for the staff who have experienced a trauma event in their workplace is that they will have to return to the site of the event. Most individuals who are traumatised do not return on a daily bases to the site of the event. It is normal for people who have been traumatised to develop phobia reactions and fears associated with the event site.

The model considers the need for preparation of new staff and the training of staff who work in these high risk areas. The training promotes self monitoring as well as knowledge of the physical as well as the psychological impact of trauma. This proactive approach promotes psychological wellbeing and helps the development of personal growth and resilience.

The paper will present results from the data and case studies to illustrate how the model has developed and the outcome after one year. It will suggest areas for future research and development of a culture that challenges the notion that 'It happen anyway', aggression and violence in the workplace.

In the first year of development 190 staff accessed the service for 1: 1 sessions, 130 of these were for staff assaulted by patients and traumatised at work. A quick intervention model combined with organisational support from line managers has resulted in staff reporting feeling more valued.

Health & Safety at work includes both physical and mental wellbeing. The Health & Safety report 'Stress and Mental Health at Work (2009) suggests 'early intervention, talking and supporting staff' is key to positive outcomes for employees.

60 of the staff seen presented with trauma related issues that had happened at home. For the purpose of this paper, detail around the work related trauma will be the focus, including a review of the types of workplace trauma, responses to interventions, and ethnographic data.
Themes that have emerged which have implications for the working practices of the Charity will be discussed, along with future developments for the service for staff as part of an overall staff wellbeing project.

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Correspondence

Mrs Annette Greenwood
St Andrews Healthcare
Billing Road
NN1 5DG
Northampton
United Kingdom
+44 1604 616 149
agreenwood@standrew.co.uk

Positive environment program: Challenges and opportunities experienced in United Arab Emirates - Preventative action the key

Paper

Hiraina McKenzie
Tawam Hospital affiliated with John Hopkins International, United Arab Emirates

Introduction

Zero tolerance of aggression and violence matters, if you want a healthcare service that provides excellence in patient care and maintains a high caliber of staff. International research has recognised the intrinsic link between staff morale, work stress levels and patient care standards. There has been limited research on this subject in the Middle East. Lebanon participated in combined project led by ILO, INO & PLO that Martino refers to his work. (2003, Martino,V.) In the United Arab Emirates there has been no published research undertaken on this subject.

Tawam Hospital organisation decided this was the direction needed to achieve the goal of providing excellence in health services to the people of Al Ain and to address issues highlighted in an Australian Best Practice Survey. In 2007 Tawam Hospital completed an extensive independent survey which identified that 68% of nursing staff experienced aggression and violence everyday during the course of their work. Tawam Hospital's challenge was now they had the information what were they going to do about it? This oral presentation will share with you some of the challenges and the strategies utilized to address these as well highlight the opportunities that came during the process.

Context

To give some understanding and context of this presentation we need to set the scene. Tawam Hospital is located in Al Ain which is part of the larger emirate of Abu Dhabi. Abu Dhabi is the largest of the seven emirates that constitute the United Arab Emirates (UAE). The UAE came into being only 38 years ago to unite seven regions located on the Arabia Peninsula Al Ain is an oasis in the desert with total of population 500,000 with the majority being locals or nationals of the UAE. The total UAE population is 5 million with only 22% being local nationals at 900,000 in numbers. As you can see the majority of Emirati's live in Al Ain and that non locals or ex-pats make up the majority of people living and working in UAE. This is reflected in the traditions and customs being more prevalent in Al Ain than in the westernized cities of Dubai or Abu Dhabi.

Tawam Hospital is a 500 bed hospitals that provides the full range of tertiary and outpatient services. UAE health system utilizes the American model of health provision of health insurance but with some variances whereby all people deemed local nationals are provided with comprehensive insurance cover at no cost to them. Tawam Hospital has a long history with the people of Al Ain as it was built by the founding father of the UAE Sheikh Zayed (May God bless his soul), to provide health services for his people. Local people consider Tawam to be "their hospital" and treat it as such.

As a result of the Best Practice results Tawam Nursing Executive employed a senior mental health nurse in 2008, to develop and implement a strategy that was to be sustainable and effective in meeting the organisation needs. Guidelines on positive workplace environment (ICN) and international data on managing aggression in the health care were utilized to develop a five year project called Positive Environment Program (PEP Project). Initially program was piloted with 311 staff with a view to extend to all employees, a total of 3500, if program proved effective.

Methods and results

PEP Project identified the way forward required more than a "Zero Tolerance" approach. Ideal approach is to use is a balance of prevention and intervention strategies. A multi systematic approach that involves all levels within organisation is imperative to promoting organisational change required as well as maximizing resources in a sustainable and effective manner. A needs analysis was completed using best practice modalities, SWOT and PEST framework to specify organisation strengths and opportunities for

development. This formalized the actions needed to achieve the goal of improving work environment and reducing aggression and violence. Strengths were a stable management membership and a defined leadership structure. There were indications that ineffective communication and poor management / leadership skills are problematic at senior level. Consequences included inconsistent processes, numerous "avoidable" conflicts and an acceptance that bullying behaviours were normalized as part of the Tawam Hospital environment. Insufficient psychological support for staff was recognized as an area of need, particularly if culture changes were to be implemented. An opportunity exists in Tawam establishing a working example within UAE that other healthcare organisations may wish to adopt. Literally the project was developed on a "clean canvas" with no set precedence, broad expectations and limited resources.

Key strategies were in the following four areas: - Education / Awareness of workplace bullying, Staff Psychological Support, Policies and procedures and organisation Leadership.

Strategies for change

Utilizing recommendations identified as Best Practice for healthcare services in both private and public providers internationally. Three strategies were developed and implemented.
1. Establish a staff supports service.
2. Raise awareness of Workplace Bullying and provide education on skills to manage such behaviours
3. Develop policies that support positive workplace principles of fairness, authentic leadership,

Just briefly we will explain about staff support and policies. Employee Assistance Program (EAP) was established for Tawam nursing staff. This process involved firstly promotion of the service and education on the purpose of the service. The whole concept was quite foreign to many staff. Then there was the development of referral process. Last but not least we needed to establish a rapport with staff to enhance trust in EAP. Policy development has been slow but steady progress within the organisation. Defining a benchmark of unacceptable behaviours and potential consequences was imperative for the sustainability of the PEP project. Policy and procedure provides the structure for the whole project i.e. where and how it sits within the organisation. It also facilitates accountability from all who work at Tawam Hospital.

Development of nursing leadership at senior level has not been a clearly defined process in this project. Education and training workshops are part of it but mainly it is through consultation and advisory function with issues arise pertaining to staff, individual or teams. Main strategy for discussion in this presentation pertains to the education and raising awareness of workplace bullying. The process was labour intensive as it involved working with nursing staff closely starting with defining the fundamentals. There needed to be accepted norms and agreed understandings of what constituted respect, fairness and what actions demonstrated these things.

For three months a program was implemented with eight units (seven inpatient units and one clinical support service). This involved a total of 311 staff who were mainly nurses.

Each week two, half day workshops were facilitated with a total of 24 workshops completed after three months. Managers submitted names for each workshop as rosters permitted. All Staff were given overtime if they attended on their day off and were awarded Clinical Education units (CEU) credits of 3.45 hours for each workshop they attended.

Six education topics were covered in the program.
1. Communication & challenges
2. Leadership
3. Team Dynamics
4. Team Roles
5. Valuing Difference
6. Incivility – Workplace bullying

One hour team supervision sessions were also established. These occurred each week throughout the three month program and were facilitated by staff support specialist.

Discussion

In essence the strategies of increasing awareness and giving appropriate education appeared achievable and realistic but proved to have many challenges. Working with a staff mix of 26 different nationalities who have English has their second language was the first hurdle. They all spoke English but comprehension levels varied so understanding of nuances was problematic. They had literal understanding of the words associated with aggression and violence but not all the same. Additional challenge was the context of providing care to local people of Middle Eastern and Muslim culture as the predominate patients. Specifically pertaining to culturally accepted behaviours being contrary to principles of a positive work

environment. This means some behaviours and actions taken out of culture context would be deemed aggressive and even violent at times.

Examples usually involve situations of extreme stress. Like when a local family member passes away all the family are present and with that come lots of people whaling, hitting out and bouts of verbal aggression that is sometimes directed at the staff. This may happen for over 30 minutes and usually afterwards the family members are very contrite and apologetic if they caused any harm to staff. But this is an accepted cultural norm that in many ways is a mandatory form of grief. Another example is an admission to hospital of a local family member. It is the head of the family role to ensure their loved one receives the best of care and services, if they don't do this they are viewed badly by all as not having met their responsibility. Hence at times the person appears demanding, rude, aggressive and constantly asking to speak with the senior person e.g. doctor.

To embrace cultural diversity means to be reception to different ways of doing things and acknowledging the difference between your own ways and that of others. During the PEP program it was often observed that staff spoke of accepting cultural diversity but their interpretation differed. Although they know there is difference that doesn't mean they have to change the way they care for patients or the way they interacted with patient's families. This created challenges and caused many misunderstandings between staff to patients and their family as well as between staff to staff. Staff's individual values, their perceptions of situations and their expectations of others were constantly challenged when they worked and yet there was no forum they could discuss this safely. Interactions and group work during the workshops as well as the weekly supervision sessions provided the opportunity to discuss and look at strategies that would help, starting with more self awareness. Self awareness achieved by asking more questions of each other, maintaining that discussions are a "normal" and healthy aspect of working together as a team and utilising the available resources more (interpreters, supervision, EAP).

Perceptions of what is trust and respect as well as what behaviours demonstrate trust and respect were surprisingly quite varied. Again this was culturally based with 26 different nationalities and even more different cultures within the nursing group. This formed the basis for most miscommunication and misunderstandings. So during the workshops key areas of Valuing Difference, Team Dynamics and Incivility, needed to be addressed before even considering working on effective communication and the Challenges

Effective Communication was to be the key and the catalyst if there was to be culture change in the organisation where aggression and violence was no longer an accepted behaviour. Preventing or reducing the number of incidents involving aggression had to start with how nurses communicated with each other and the people they cared for. Self awareness, knowledge and the support to actually practice what they learnt in the workshops. Support came from the weekly supervision sessions on site and the development of policies and procedures that set the benchmark of behaviour standards and expectations.

Summary

To implement strategies that address aggression and violence in the health sector in any context is a challenge. Attempting this in the UAE has additional aspects that needed to be considered first before any progress can be made with any strategy to be implemented effectively. Staff self awareness and communication skills development comes when an organisation provides the knowledge and training, the support for staff to apply the skills and the overarching framework to bring it all together.

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Correspondence

Mrs Hiraina McKenzie
Tawam Hospital affiliated with John Hopkins International
Tawam Street
Al Ain
United Arab Emirates
+971 3 707 5777
hmckenzie@tawamhospital.ae

"Perivention" development: an opportunity to avoid WPV events, lessen individual impact, and expedite recovery of staff-victim and operations

Paper

Michael Privitera
University Of Rochester Dept of Psychiatry, Rochester, New York, USA

Introduction

Terminology in the prevention literature has helped conceptually focus efforts where needed to be most effective. Whether the disease, situation or event in question best fits the particular prevention terminology model has caused researchers to select different terminology models depending upon the area of study. This paper will briefly review existing prevention terminology. Some of the limitations of these current models in producing more effective workplace violence (WPV.) programs are discussed. The rationale of a new term, *periventions* (1), is reviewed. Use of this concept is offered to better focus needed efforts with time and location sensitive interventions that have the potential of significantly improving outcomes in healthcare related work place violence.

Main paper

Background on injuries

Injuries have two main categories: *unintentional and intentional*. In general and mental health care, examples of unintentional injuries may be from violence coming from a mentally incapacitated patient -- ill due to medical reasons (like delirium), or severe psychiatric symptoms (like paranoid delusions in a psychotic patient). Intentional injuries have human motivation, directed *toward* self (suicide, self-injurious behavior), or outwardly such as homicide, threats, assault, etc.

In health care, this *outwardly* directed violence can occur from mentally incapacitated patients, but also by mentally capacitated patients (who know right from wrong), visitors, or other staff, who may purposely injure a staff member. In this latter category, there usually is a discernible specific non-psychotic goal (e.g., intimidation, punishment, perceived retribution).

Injuries are diverse in mechanism of occurrence. An increasing amount of literature demonstrates evidence for significant impact of both emotional as well as physical injury on the individual and system (2, 3).

Although the traditional epidemiologic causal model for infectious disease can be adopted for traumatic injuries, the opportunity to address time- and place-sensitive interventions can be *diluted* by the expanse of the primary prevention and tertiary prevention periods of time.

A review of the public health approach for injury control follows: One's *environment* may be influenced by social, economic, demographic, cultural, and physical factors. Opportunity for interventions to avoid the transmission of *energy* or lessen its impact is possible through changes in characteristics of the *vehicle*, *vector*, and or *host*. Energy can take many forms and only this traditionally refers to thermal electrical and mechanical energy. However in human situations of injury verbal abuse and threats would also be included. Energy is transmitted through a *vehicle* (an inanimate object like a weapon), by means of a *vector* (an animate object like a person). *Host* in the causal model of injuries in the healthcare workplace is the staff victim or potential victim.

To prevent" literally means "to keep something from happening." Different ideas exist about what that something is: the first incidence of a disorder, relapse, and disability associated with a disorder, or the risk condition itself. These different concepts constitute a source of confusion in the field of mental health regarding the term *prevention*.

The Commission on Chronic Illness (1957) established the Public Health classification system of disease prevention (4):

- *Primary prevention*. The goal is to decrease the number of new cases of a disorder or illness (incidence). These are approaches that take place before the injury and/or violent event and that prevent the injury, such, fences around swimming pools, as modifications to roadways that prevent crashes etc.
- *Secondary prevention*. The goal is to lower the rate of established cases of the disorder or illness in the population (prevalence). These are approaches that take place during or immediately after the injury and/or violent event and reduce the severity of the impact (such as, air bags, helmets, seat belts or bullet resistant barriers).
- *Tertiary prevention*. The goal is to decrease the amount of disability associated with an existing disorder or illness. These approaches deal with preventing the lasting consequences of injury and/or violence, such as victim's assistance programs, emergency care, or rehabilitation.

Gordon (1987) was convinced that practically-oriented disease prevention and health promotion programs could be based solely on empirical relationships (based upon a risk-benefit and cost-benefit point of view) (5). That is, the risk to an individual of getting a disease must be weighed against the cost, risk, and discomfort of the preventive intervention. His classification was as follows:

Universal preventive measure. This is desirable for everyone in the eligible groups like pregnant women, children, and the elderly. These measures can be confidently advocated for the general public and all members of specific groups (e.g., seat belts, adequate diet).

Selective preventive measure. This is desirable when the individual is a member of a subgroup of the population whose risk of becoming ill is above average. These subgroups may be distinguished by occupation, age, gender, family history, or other evident characteristics (e.g., annual mammograms in women with family history of breast cancer, yellow fever immunizations for those who travel to high-risk areas).

Indicated preventive measure. This is desirable for those who, on examination, are found to manifest a risk factor, condition, or abnormality that indentifies them, individually, as being at high risk for future disease development. These measures are usually not totally benign to the subject or minimal in cost (e.g., frequent careful examinations after a localized basal cell cancer has been removed). If the measures were more benign and less costly, the balance in the benefit–cost analysis might favor their wider application, including segments of the population at lower risk of disease and they would tend to move into the selective or universal classes. Gordon saw *treatment* as different than *indicated preventive* measure in that the latter was "asymptomatic, (but had a) clinically demonstrable abnormality."(5) Suicide prevention research has tended to favor Gordon's classification over the Public Health classification.

Uncovering the need for a new term

A great deal of research on WPV has been conducted throughout the world in the general and mental health care settings that follows the public health classification. These are also the type of studies that yield high quality data in experimental design and are also influential in making institutional, community, and regulatory agency policy.

Given the rapid decline of safety that can occur in WPV in the moment, there is great need for filling this gap of knowledge for what to do acutely at the individual and institutional levels to modify the interpersonal and other factors involved in the potential or actual violent incidents.

Over years of operation of our Workplace Violence Committee at the University Of Rochester Department Of Psychiatry, the issues that needed the most clarification and development were about those that referred to the time and location of increasing risk of potential violence, during the violent episode, and what to do immediately after the violent episode-- to avoid violence or lessen the impact, confusion, bewilderment, and impaired institutional operations that follow events. Existing terminology did not seem to adequately address the lacking area of interventions that were deficient, poorly defined or poorly developed. Conceptually, the interventions that needed to be developed were difficult to easily classify. In time it became clear that the missing elements of workplace violence prevention and management, showed a pattern of being time and location sensitive interventions around violent events or potentially violent events, and existing terminology appeared to detract from their recognition. Because of the substantial number of human interactional factors involved in healthcare related workplace violence, potential exists for modification of interactional factors that can alter the course of potential or real workplace violence. These situations, thus, pose opportunities that differ from infectious disease, vehicular accidents and even suicide prevention and management.

Since WPV episodes are of such high-impact when they occur, better focus needs to occur about interventions in this period around the time of a potential or actual event. The rest of this chapter is devoted to the reasoning behind the new term periventions - to apply to interventions at this exact period of time that focuses on interventions that can be helpful immediately before, during, and immediately after a potential or actual violent event. The hope is by using this term that was first introduced elsewhere by Privitera (1), more emphasis will be placed upon this critical period to improve what appear to be missing pieces in many existing WPV programs, -- dealing with the key word of violence or potential violence itself.

In WPV in healthcare settings, there may be opportunity for many modifiable factors at the high-risk times to either be able to successfully avoid the violence from developing, or to lessen the impact of the violence on the individual(s) affected. Although there may be static characteristics of perpetrators and victims that may make them more likely to be part of violent scenarios, in healthcare settings it may be a combination of factors that suddenly raise the risk of a violent event. Intimate partner violence (IPV) at work may be an exception to the preceding statement as these events may be more calculated and planned. However even IPV still holds potential to benefit by understanding and dealing with factors that are time sensitive to the raised violence risk or post event.

New Term Construction
a. Current terminology components
   Pre: Latin (prae) prefix—meaning before in time, place, or rank (e.g., prevention)
   Vention: Latin (venire)—meaning come
   Inter: Latin (inter) prefix—meaning between
   Intervention: Coming between to modify, settle, or hinder some action7
   Post: Latin (post) prefix—after in time, later (than); after in space, behind. (e.g, postvention)

b. New term construction logic
   Peri: Greek (peri) prefix—around, about, or near.
   • *Time* application of prefix used in Obstetrics and Gynecology
       1. *Perinatal*: Peri (around) + natalis (birth)
       a. Concerning the period beginning after the 28th week of pregnancy through 28 days after birth
       b. 22 completed weeks of gestation through 7 days after birth (6)
       2. *Perimenstrual*: Peri (around) + mensis (month)
       a. 4 days prior to menses, to 5–8 days after menses (7)
       b. 2 days before menses through first 3 days of menstruation (8)
   • *Location* application of prefix in Dentistry and Cardiology
       1. *Periodontal*: Peri + odous (tooth)
       a. Located around a tooth (6)
       2. *Pericardium*: Peri + kardia (heart) and
       a. The thin sack surrounding the heart (9)

c. Perivention: Peri (around) + venire (come)
   • The term *perivention* is being proposed to capture those interventions that incorporate the following time and location implications:
       a. *Time*: The interventions would occur right before, during, and right after a potential or real violent event occurs. They would include features of some primary (but time proximal to the event), secondary, and tertiary prevention (again time proximal to the event).
       b. *Location*: Ideally the interventions begin to take place or appropriate referrals begin at or near the area the event is occurring (1).

Examples of Need for Rapid Interventions:

a. There is the potential for Posttraumatic Stress Disorder (PTSD) to be prevented or lessened in impact depending upon the timeliness of the intervention, before disturbing memories and emotions of the event get written into the brain's amygdala (the part of the brain associated with emotion and memory, and symptoms become entrenched and chronic(10). A number of studies have looked in biological interventions within a certain amount of time from the trauma to be effective. Examples include studies of use of beta blockers post trauma (11, 12), morphine use in soldiers post trauma to prevent PTSD (13). Social mediators of recovery in the immediate aftermath of trauma have an extremely important role and a profound biological effect, as well. Violence may have significant psychological and physical affect on the victim requiring immediate comfort and support as well as ongoing communication after the threat or the assault occurs. There may be a high risk group of staff injured at work that may have had previous trauma that this new event or set of events exacerbate (14, 15, 16, and 17). Suicide and even death has been reported associated with workplace violence events (17)

b. Physical injuries without rapid intervention may affect the capacity for the individual to optimally function when delays in treatment occur. Contractures and loss of mobility are example of problems from delays in physical therapy, orthopedic intervention, etc. Confusion over health insurance coverage versus Worker's Compensation coverage may significantly play into these delays.

c. Situations of morale, perceived staff support and job satisfaction have been shown to be involved in the system's response to the staff's personal early experiences with WPV. Psychological functionality in

patient care may be affected by the system's early response to the event (18). Main (2002) has been very influential in increasing awareness that certain working conditions and adverse workplace characteristics may place an individual at increased risk of disability and associated absences from work. Additional factors of note include the perception that the style of management is unhelpful and the belief that they receive poor social support from their colleagues (19).

d. In musculoskeletal back injury, it has also been found that individuals appear to be at risk of not rapidly returning to work after injury if they experience a delay in income support, such as disability or workers' compensation; and have had prior experience working with an ineffective and/or punitive case manager.(18)

e) There is increasing recognition that early intervention is increasingly seen as central to the prevention of long term disability. Psychosocial risk factors influence the onset and maintenance of disability suggesting early interventions for their management (20, 21, 22)

Examples of Periventions that deserve more focus

a. Directly before potential violent events
- Reading early signs of escalation, being personally more vigilant and engaging needed sequences as per training
- Using de-escalation techniques, both verbal and non verbal.
- Hearing and resolving patient concerns that are distressing and escalating the patient
- Teamwork among non-clinicians and clinicians to work together prevent or lessen the impact of violence-this can in itself discourage further escalation that may be occurring toward a single individual.
- Early notification of security or police (as relevant to location) for protective presence and to deter further escalation
- Security unseen but nearby presence when working with high-violence risk patients
- Security walk-by plans on wards with identified high-violence risk patients at times of nursing care of the patient or medication times.

b. During violent events
- Further de-escalation techniques of verbal violence to lessen risk of progression to physical violence, or contain it to what has already occurred.
- Having Security present with verbally violent patients
- Use of escape and punch block techniques from physically violent patients
- Teamwork of non-clinicians and clinicians in activating alarm systems to call for help (Security/Police/Ambulance/Internal Crisis Intervention Team as relevant)
- Teamwork to manage acute milieu environment (the violent patient, other patients, visitors, etc.), to lessen risk of violence to others

c. Directly after violent events
- Teamwork to keep institution functioning as normally as possible
- Supportive style of supervisor regarding necessary fact finding, paperwork, referrals to medical care, and dealing with police and security reports
- Immediate relief of the staff-victim's duties to attend to urgent physical, emotional, and legal issues
- Engagement of post-event protocols
- Assessing together (staff and administration) the opinion as to whether the patient knew right from wrong in their actions, but ultimately supporting the victim in their decision on how to proceed if legal options considered.
- Establishment of other staff notification plan to lessen the re-traumatization of the staff victim that occurs by telling their trauma story repeatedly to other interested/well-meaning staff.
- Supervisor meeting/communicating with other staff to notify them of essentials that address what happened, status of the staff-victim (information as agreed upon by the staff-victim and supervisor together), steps to take, and issues relevant to their own safety
- Appropriate referrals to medical care or counseling through Employee Assistance Programs (EAP) — should be offered immediately and preferably on location.
- Education of staff-victim of their legal options when relevant, or beginning referrals to address their options
- Connection to a staff ombudsman, whose role is help guide the staff-victim's upcoming journey through the complexity of intramural and extramural contacts and navigations that are likely to ensue.
- Facilitating the opportunity to take care of necessary legal, medical and personal needs that result from the work-related violence would be part of the managerial support to the staff victim that may modify the

effect of that violence. Written post event protocols help supervisors and staff understand that taking care of these aforementioned needs are legitimate activities, and are supported by corporate policy.

Conclusions

The term *perivention* will hopefully draw attention to the missing elements in current WPV Programs, and enhance needed focus to develop this set of life, disability and career-saving interventions.

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Correspondence

Mr Michael Privitera
University Of Rochester Dept of Psychiatry
300 Crittenden Blvd
14642
Rochester
New York
USA
+1 585 273 5701
michael_privitera@urmc.rochester.edu

An integrated health response to partner violence: lessons learned from two Northern States in Malaysia

Paper

Manuela Colombini, Susannah Mayhew, Charlotte Watts
London School of Hygiene and Tropical Medicine, London, United Kingdom

Background

Evidence on interventions seeking to address intimate partner violence (IPV) by integrating specific services at the health sector level remains limited. The One-Stop Crisis Centre (OSCC) in Malaysia is an internationally recognised, integrated health sector model that aims to provide comprehensive care to women experiencing abuse. Based on a multi-sectoral approach, OSCC provides comprehensive services such as counselling, medical care, support services, police and collection of forensic evidence, legal aid and temporary shelter, all in one site. The OSCC is based at the Accidents & Emergency (A&E) departments of mostly all public hospitals, thus benefits from their round-the-clock operational hours. The rationale behind the implementation of an OSCC model was to provide comprehensive services in one site, with the potential benefit of geographical proximity to all services, reduced or no delays for examination, additional referrals to specialised services, and more patient-centred care. Counselling is often offered on site by the counsellor, at tertiary hospitals, and by the medical social workers at secondary hospitals, and upon referral by women's NGOs or social workers from the Department of Social Welfare. Internal referral systems are created to refer cases from OSCCs to other specialised services on-site; while an interagency network including police and social workers is crucial for external referrals.

Aims and objectives

This research explores the pathways of care offered to sexually and physically abused women, and the practices around OSCCs at different levels of hospital care in two Northern States in Malaysia. In particular, it aims to: 1) describe the organization of 7 OSCCs in Penang and Kelantan; and 2) analyse how, why and the extent to which, the documented OSCC practices and processes differ from the procedures prescribed in the hospital's guidelines. Challenges faced by these health settings when providing services for abused women are explored.

Methodology

This research is based on data from in-depth interviews with 54 health care providers, 8 policy makers and 12 key informants, as well as from document analysis of hospital records and protocols, and site observations of the OSCC settings in 7 hospital facilities.

Results

Policy-practice Differences

The findings show that the implementation of the OSCC model varies substantially and is influenced by systems and organisational constraints. Often hospitals or health providers are willing to offer care to abused women, but they are not fully supported within their facility due to lack of training, time constraints, limited allocated budget, or lack of referral system to external support services. For instance, although the regional hospital in Penang had designated staff for OSCCs, a specific separate room for offering the services to abused women, not all providers were trained in OSCC procedures. Non-specialised hospitals in both States were struggling with the scarcity of their human resources and a limited referral system. Despite the challenges throughout the implementation process, several examples of good practice and of committed individuals are also acknowledged.

A national circular from the Ministry of Health (MOH) on the creation of OSCCs [2] and guidelines on the management of OSCC care, developed by the hospital Kuala Lumpur [3] detail the specific services that OSCCs should be provided. Most visited facilities had specific OSCC procedures, which were based on these national guidelines, and therefore had very similar procedures for OSCC cases. In general, although

most facilities had at least a standard MOH protocol for rape or child abuse, there were no explicit hospital protocols for IPV, apart from a checklist form for battered women to guide doctors on how to interview and record cases of domestic abuse (primarily at tertiary hospitals).

The reality of the patients' flow and the organisation of the care offered to abused women is not as clear as it appears in the available hospital protocols, flowcharts and guidelines. In Malaysia, there has been a discrepancy between the procedures detailed in the stated guidelines and their actual implementation through OSCCs. Findings show that organisational and policy barriers limit the full integration of OSCC services:

- Training is not sufficient and is focused on clinical interventions for rape;
- No protocol for IPV cases, only for rape and child sexual abuse;
- Shortage of trained and designated staff, especially at district level;
- Weak referrals between hospital units and limited coordination across agencies;
- Lack of clearly defined roles among various health and non-health actors involved;
- IPV not prioritised by senior policy-makers because of other health competing priorities.

Challenges and factors at different systems-levels are interlinked and, therefore, they cannot be addressed separately.

Integration Challenges

Despite the principle of geographical proximity being key to OSCCs, the care they provide is often fragmented and not always provided in one site, especially at district level [9], with a lack of resources both within the hospital and externally limiting options for comprehensive service provision. Several challenges exist in relation to the integration of comprehensive care through OSCCs, ranging from lack of staff sensitivity and awareness to time shortages, staff rotation, limited collaboration with agencies, little training, no protocols on IPV and budget constraints. Among many others, lack of knowledge about violence prevention among health personnel and the public, and inability to recognize cases early and manage them appropriately are observed to be two of the causes of underreporting among women.

Sustainability issues

Despite the support of MOH and women's groups, several issues are of concern when focusing on the long-term sustainability of OSCCs. For instance, the high staff turnover at hospitals may lead to a weakness in trained personnel. Another issue is the shortage of personnel, especially in district hospitals, where specialised staff are not available (like forensic officers) or women's groups are not available to provide volunteers and referrals for shelters. Some concerns exist about the multi-sectoral collaboration between the hospital and other agencies, as the follow–up of the cases referred appeared to be a challenge, particularly at district level where few support services are available. Moreover, managing expectations regarding the roles of different agencies was also challenging as the roles of each agency (e.g. MOH, NGOs, Social Welfare) was not clearly defined when the OSCC was created. For instance, the findings show that a misunderstanding between the government and the women's NGOs about their respective roles in supporting OSCCs led to a breakdown in their partnership, which negatively impacted on the long-term implementation of the OSCC policy.

Besides interagency collaboration, the lack of training and the lack of financial and human resources constitute another problem. The OSCC model described in the MOH circular and in the national guidelines is based on the services and resources of the tertiary hospital of Kuala Lumpur. It is thus based on the assumption that the infrastructure and support services would be available. In reality, when translated to the different hospital facilities, the implementation of the policy inevitably encountered problems when expanding the comprehensive model of OSCC services to settings with only basic care and limited support services. The challenge for Malaysia now is to secure government commitment to properly resourcing the OSCCs throughout the country.

Local Adaptations

Adaptations of the model vary depending on the local context and on the level of hospital care, with the OSCCs at tertiary level being most developed and comprehensive reflecting the higher availability of human resources and services. Moreover, because of the higher exposure to training, the people from tertiary hospitals are more aware about procedures than the ones at lower levels of hospital care. Referral hospitals have medical officers in charge of OSCCs, while medical assistants or staff nurses are in charge in smaller district hospitals. Only some referral hospitals have medical social workers or counsellors, thus in most district hospitals, informal counselling is very often offered by staff nurses or medical officers, and women are then referred to psychiatric clinics of tertiary hospitals for specific psychological support. Therefore, even with political will and a guidance framework, the policy implementation is constrained by local resources, with the existing health service structure and capacity determining the true effectiveness of integrating OSCC care.

Despite the official scale up of OSCCs to all facilities, even at district level, none of the hospitals received any additional budget for the creation and running of the centres, but each setting used the A&E budget for any expenses encountered at OSCCs.

Conclusions and learning outcomes

Malaysia is leading in the running of integrated services - through its OSCCs - to women who experience sexual and physical abuse. The adaptation of the OSCC model varies substantially, depending on the local context and on the level of hospital care. Especially in tertiary hospitals, OSCC care is often fragmented with a lack of resources both within the hospital and externally limiting options for comprehensive service provision. Therefore, the replication of the model in other similar settings needs adaptation of the service model to different facilities and levels of care, and to available resources. There should also be more coordination with Social Welfare and other agencies.

Lesson Learned and Recommendations

OSCC services can be one of the protective factors against gender-based violence as they provide an entry point and an opportunity for women to come forward and get help. Having specific services located in one site helps offer care with privacy and confidentiality and promote women's needs. Geographical proximity of all services in one site and the interagency network are important elements of the OSCC model. However, different approaches to the integration of OSCC services should be considered according to the level of hospital care and the resources –human and financial – available.

Specific recommendations

- Ensure top-level commitment to gender-based violence (GBV);
- Help create a supportive environment for health staff by ensuring financial and human resources at OSCCs (e.g. strengthen current hospitals' service infrastructure and increase human resources);
- Develop specific standard protocols for IPV;
- Develop a training for core skills on counselling and communication on sensitive topics (including GBV) to improve staff awareness and understanding of GBV and gender issues to be run at medical schools as well as in-service training;
- Strengthen collaboration and referrals within hospital units and across agencies including NGOs;
- Train providers at primary health care around GBV issues;
- Run public awareness campaigns to help raise public awareness about existence of OSCCs and about condemnation of GBV.

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Correspondence

Mrs Manuela Colombini
London School of Hygiene and Tropical Medicine
49, Bedford square
WC1E 7HT
London
United Kingdom
+44 207 299 4620
manuela.colombini@lshtm.ac.uk

Essential infrastructure and positive outcomes of an innovative approach to violent incident team response in acute care settings

Workshop

Leslie Gamble, Shelley Smillie, Shannon Campbell & Clayton Towpich
Interior Health Authority, Kelowna, Canada

Abstract

In 2006, Interior Health, a health authority in BC, Canada, was experiencing considerable difficulty in recruiting and maintaining acute care staff volunteers to assist in providing a 24/7 team response to violent or potentially violent incidents at many of our acute care facilities. Thus, in 2007, our authority embarked on developing and implementing a new staff education violent incident response team curriculum as well as developing the necessary infrastructure to support these newly formed teams. This paper outlines the steps and the comprehensive infrastructure required to develop and sustain a violence response team in a regional/tertiary acute care facility. It also includes the statistical outcomes of the Violence Response Team interventions at three of our largest acute care sites in 2009. The outcomes of this new approach have far exceeded Interior Health's expectations and reveal that these sites are truly impacting a culture of respect and safety for our staff, our external security providers and our patients.

Introduction

In 2006, Interior Health, a health authority in the province of British Columbia, Canada, identified through staff, manager, site administration and union feedback that there was a significant lack of confidence in our acute care site's ability to effectively intervene and respond to violent or potentially violent situations. Efforts to recruit and maintain staff volunteers to participate in Code White (violent incident) Response Teams meant that many sites did not have a sufficient number of trained responders to assist in managing these situations. Staff and management also reported the following:

- By the time a Response Team was called, the situation was usually well beyond the team's ability to de-escalate the individual and therefore the majority of interventions required hands on physical containment. This not only placed the patient/visitor at increased risk but also placed the staff at increased risk of physical and emotional injury.
- The current violent incident response training did not prepare them for the reality of violence they were facing
- There were no defined roles or responsibilities of the team members and their approach to incidents was not consistent
- Resources required by the response team were not readily available (e.g. mechanical restraints)
- There was lack of clarity of the role our external security officers played in these situations

Thus in 2007, Interior Health placed priority on developing a new, more comprehensive approach to violence intervention in our health authority. An extensive review of all aspects of existing approaches and available literature within our authority, our province and internationally was conducted. While the literature was ripe with information on the increased violence in the health sector [1,2,3,4,5,6,7,8] and a need for a comprehensive perivention approach to ensure effectiveness and sustainability [9,10] few of these prior to 2007 provided practical and clear solutions in relation to team intervention. However the work done by Meehan et al [11] was valuable in its emphasis on the need for a multi-strategy approach to reduce aggressive behaviours and staff injuries.

While the initial lack of information and clarity was disheartening, Interior Health saw opportunity to be innovative in our approach to developing a more defined approach to violence in our acute care facilities. The following beliefs helped our health authority develop our new program:

- Staff education was only one component of a successful program. It was necessary to develop infrastructure at each site to support the Personal Safety and Response Team education.
- Staff education must reflect the reality of the violence in healthcare

- By initially focussing on reactive "in the moment" solutions to managing violence or potential violence, sites could use the momentum this created to identify key individuals to further develop the reactive aspects of the program and ultimately the true upstream prevention aspects of a comprehensive Violence Intervention Program
- Given the unknown and varying situations requiring intervention and the potential high risk that a team member assumes with each intervention, members must be comfortable participating in all levels of de-escalation and physical containment. Thus voluntary participation in the team is essential.

The recent article published in Workplace Violence in Mental Health and General Healthcare Setting [12] has validated the VIP belief that the staff education component must more accurately match the level of violence in healthcare. With these beliefs and the supporting staff feedback and literature, Interior Health was able to develop the following process to build effective violent incident Response Teams at our regional and tertiary acute care facilities.

Process Implemented to Develop the Violent Incident Response Team:

Step 1 – Determined a vehicle to create momentum
After considerable research, Interior Health teamed with an external agency, ART (Advanced Response Training) who assisted Interior Health in developing our own education platform. It was crucial that the platform was dynamic and flexible enabling supplementation of key learnings as the program progressed. The education also had to reflect the current reality of violence in acute care ensuring the physical / verbal violence mimicked what staff would be exposed to. This platform consists of:
- Personal Safety (1 day course)
- Violence Prevention Team Response (2 day course)
- Violence Prevention Team Response Refresher (4 hour session semi-annually)
- Violence Prevention Team Response Annual Recertification (1 day course)

Step 2 – Determined outcome measures that could be used to support the return on investment
A working group of key stakeholders from 3 of our acute care sites developed a standardized Interior Health Response Team Incident Report form. The compilation of this report was deemed essential to monitor the program, to determine any existing gaps (e.g. not enough people trained to cover specific shifts) and to prove a return on investment. The top 3 key indicators to determine a successful return on investment were:
- Assurance that each site had enough people trained to provide an optimal 5 member response team or minimal 3 member response team per incident 24 hours a day / 7 days per week. These teams would be composed of Interior Health staff and a varying numbers of external security officers depending on the site and shift.
- Accurate identification of when and where the majority of incidents were occurring to ensure these units were adequately resourced.
- The percentage of incidents that required hands–on / physical intervention. It was initially perceived that the vast majority of team responses prior to the new program resulted in physical interventions. It is apparent from a risk viewpoint that the risk to the staff and patients dramatically increases when physical strategies are required to contain the situation. Thus our initial aim and most powerful outcome was to reduce this potential risk.

Step 3 – Applied for an external grant to implement the program at 3 pilot sites
Worksafebc, our provincial worker compensation board, provided our organization with a grant to develop the program and pay for front line staff and external security officer participation in the education component.

Step 4 – Received commitment from senior administration at each pilot site to develop a Violence Intervention Program (VIP) Committee
This committee needed representation from managers from the units deemed as high risk for violence, interested front line staff from throughout the site and site VIP instructors (once determined). VIP site leads / committee chairpersons were determined (preferably one manager and one front line staff member). Adhoc members to these committees are the regional VIP lead, the Manager for Protection Services, the Human Resource Business partner and the city Police liaison. This committee was responsible to oversee the program at their site, ensure all education requirements were sustained and to continue to develop all aspects of the infrastructure that would support the education platform. This infrastructure would eventually be housed in their Aggressive Behaviour Toolkits.

Step 5 – Delivered Personal Safety education for high risk areas
All staff from three units at each site deemed to be at highest risk of violence were required to attend the Personal Safety course. These units included our Emergency Departments and Psychiatric Units. These sessions influenced many staff to volunteer for the Response Team training.

Step 6 – Recruited and trained Response Team
The key philosophy in recruiting staff was the need for voluntary participation in the Response Team (with the exception of our external security officers), comfort in physically intervening if required and demonstrated respect for others in conflict situations. As well, the members upon completion of the training are expected to demonstrate competency in intervening in mock violent incidents response scenarios. Those members that were not successful in demonstrating this competency were encouraged to take on a support role rather than a lead or member role.

Step 7 – Identified 2 - 3 key staff members per site who met specific criteria to become a level 1 VIP instructor
The criteria for selection of instructors consists of the need for sufficient time (either ability to be back filled or work additional hours if a part time employee), the desire, a solid understanding of the philosophy of the program, the necessary physical abilities to demonstrate physical techniques and partake in mock team interventions and effective basic facilitation skills. These individuals are then responsible to provide the semi-annual refresher education sessions, sit on the VIP committee and participate in annual instructor workshops.

Step 8 – Provided Response Team kits in strategic areas
These kits contain Team Response Incident Report forms, employee injury/assistance resources, "in the moment" practical protocols, mechanical restraints (with the exception of one site which had them readily available on each unit) and finally medication guidelines for treatment of acute agitation and aggression. The VIP committee must ensure these kits are regularly inventoried and maintained.

Step 9 – Delivered overall site education re: Violence Intervention Program and new Response Team
Prior to the "go-live" date for the sites Response Teams, site education was provided to ensure stakeholders were informed of the change in process, the contents and location of Response Team kits and mechanical restraints, when and how to call for the Response Team and how to support the Response Team once they arrive in their area. This information was provided to senior and middle management at management meetings as well as to front line staff at staff meetings and drop in sessions on the units. Two sites elected to host a celebration/information session with VIP committee members handing out cake and program information.

Step 10 – Compiled and reviewed the Response Team data
It was initially evident that all incidents were not being reported via documentation on this form. However by ensuring the incident report forms are readily available, by emphasizing the need to complete these form during all team training sessions and, most importantly by displaying/sending report analysis to team members, team members are now ensuring a form is completed following each incident. Page one of the completed reports is placed in the patient chart and copies of the entire report is given to unit managers and sent to the VIP committee. The VIP leads and unit managers then determine if the situation requires any further follow-up and ensures the appropriate resources are available. The information from these Response Team incident reports are compiled in an excel database, trended and analyzed at each site on a monthly basis and regionally on an annual basis as outlined in the results section of this paper.

Step 12 – Created detailed expectations of the program at all levels of the organization
Following the first year of the new program, the organization and the site VIP committees were able to more clearly define the program requirements and expectations. New recruits are now provided with these expectations and his/her manager must also agree to support the staff member's subsequent mandatory practice and recertification sessions. The roles and responsibilities of all key stakeholders at a site are now defined in the IH document titled "VIP Acute Care Site Lead Guide".

Step 13 – Sustained ongoing annual funding for the program
A decision brief with defined human and financial resources required to sustain the program at the initial pilot sites and to expand the Violence Intervention Program throughout Interior Health was presented to and approved by the Interior Health Senior Executive Team.

Step 14 – Further developed the internal VIP instructor process.
A clear process to ensure development of highly qualified Personal Safety and Team Response Instructors was completed. The result is a 5 tiered instructor level training process. The Interior Health VIP Leader, in consultation with ART, selected key instructors from the base of site level 1 instructors, to progress to subsequent instructor levels. This process is currently a main priority for the program.

Results

2009 Team Response statistics from three acute care hospitals within Interior Health

(*note the violent incident response in the province of BC, Canada, is termed Code White team response therefore this language is used in the following graphs.)

The following results are from Kelowna General Hospital (KGH) - a 340 bed tertiary acute care facility, Vernon Jubilee Hospital (VJH) - a 140 bed regional acute care hospital and Penticton Regional Hospital (PRH) – a 129 bed regional acute care hospital.

Total Number of Calls in 2009
With the education and unit staff orientation to the Response Team process emphasizing the need to call the team early, an expected outcome of the program was that all sites would experience an increase in the number of team response calls. At PRH, the only site that had a record of calls in 2008 showed a dramatic increase from 35 calls in 2008 to 117 in 2009. Reported calls in 2009 at KGH and VJH were 214 and 100 respectively.

Number of team intervention calls from the top 3 units at each site for 2009.
The top unit in all three sites to initiate Response Team calls was the emergency department. The second highest number of incidents at KGH was in the medical/detoxification unit while at VJH and PRH it was Psychiatry. Overall the top three units that initiated Response Team interventions were Emergency, Psychiatry and Med/surg units.

Figure 1: Top 3 Units to Initiate a Team Response Call at KGH
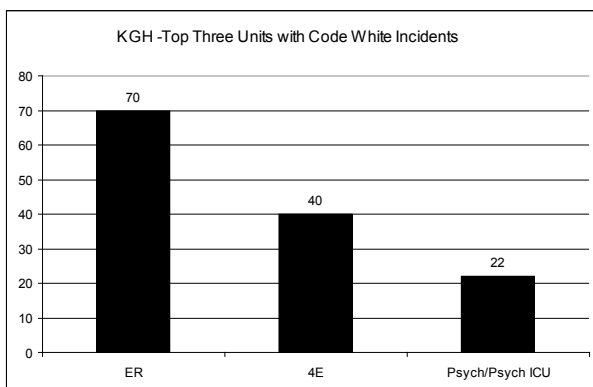
Time of incidents
The timing of the incidents were split in a variety of patterns at each site however all had less incidents called at night with KGH reporting 28% and VJH / PRH reporting significantly less with 17% and 9% respectively. The highest number of calls at each site occurred mid week and not on the weekends as originally anticipated.

Figure 2: Time of Response Team Calls at KGH
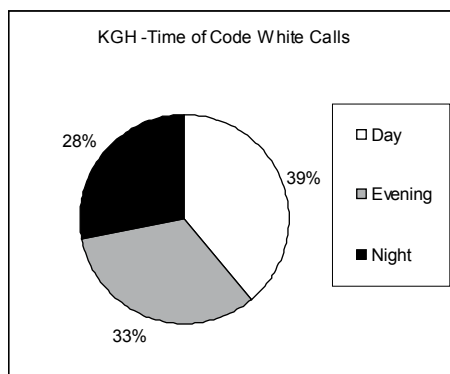
Gender of aggressor

Gender definitely plays a part with all sites experiencing a higher number of male patients involved in the Response Team incidents.

Figure 3: Gender of Aggressors at KGH
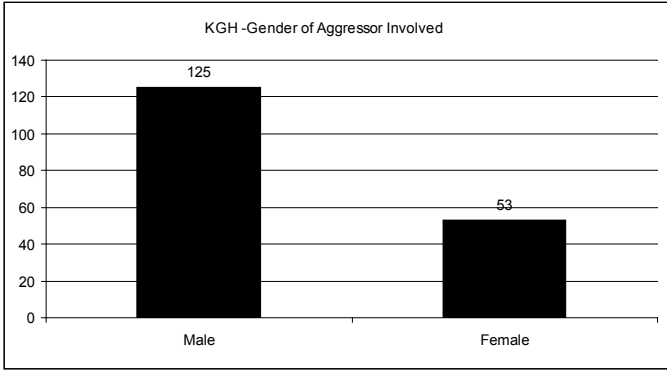
Number of trained responders

The target for our sites was to have 5 responders available during the day and a minimum of 3 trained responders available to attend to calls in evening and night shifts. The number of trained responders to each call ranged at each site from 1 to 17 per call. The chart below reflects the number of trained responders for incidents per shift at KGH and indicates that on average that 5 or more trained responders assisted during the day incidents, and 3 or more assisted in the evening and night shifts incidents. PRH statistics initially indicated there was an average of 2 trained responders assisting during the night shift. This information allowed the site to focus team recruitment efforts on shift workers.

Figure 4: Number of trained responders at team intervention incidents at KGH
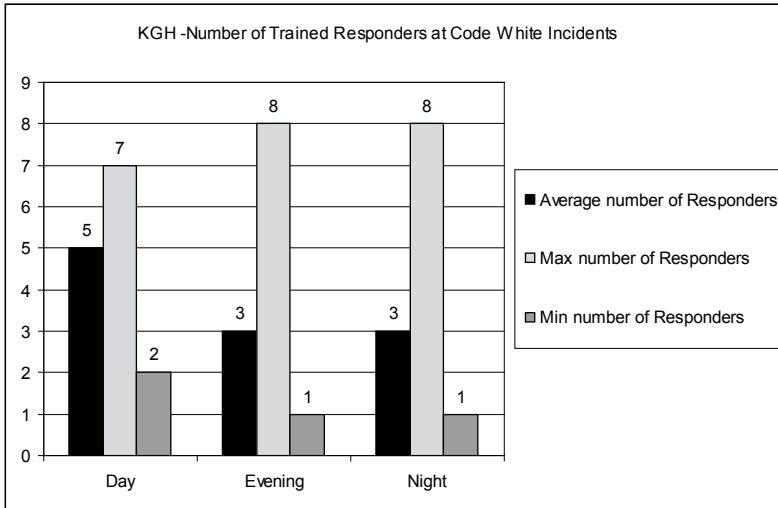
Patient behaviours / reasons for Team Response interventions

The following chart shows the frequency of behaviours exhibited by the aggressive individuals during each incident in 2009. Patients' use of belligerent language and physical aggressiveness to staff were the main behaviours observed at all sites.

Figure 5: Aggressor behaviours observed during team intervention at KGH
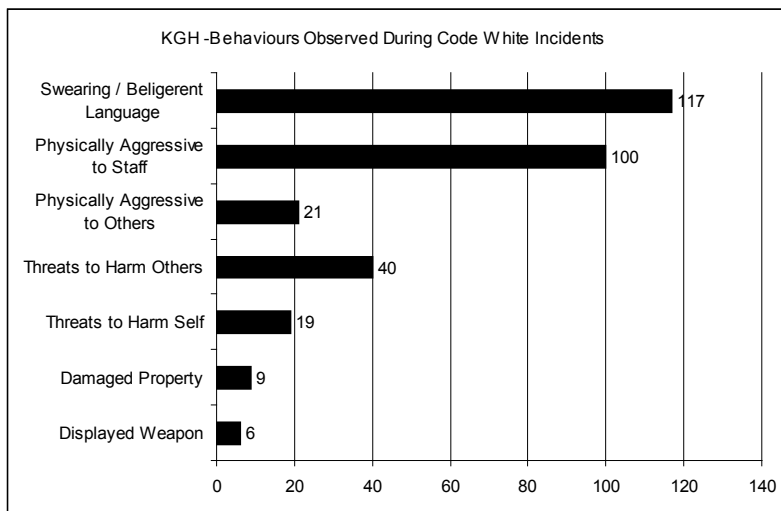
Type of Response Team interventions used

The following chart depicts the interventions used by the response teams. Most individuals required more than one intervention. The most frequent interventions used were medication administration and verbal de-escalation. To determine the percentage of incidents that required hands on interventions by the Response Teams, two categories were added together: physically contained by team and restraints applied. The percentage of incidents which required hands on intervention by the response teams ranged from 21% at PRH to 31% at KGH. This is an incredible improvement from the previous perception that the vast majority of response team interventions required physical intervention.

Figure 6: Team interventions used during team response incidents at KGH
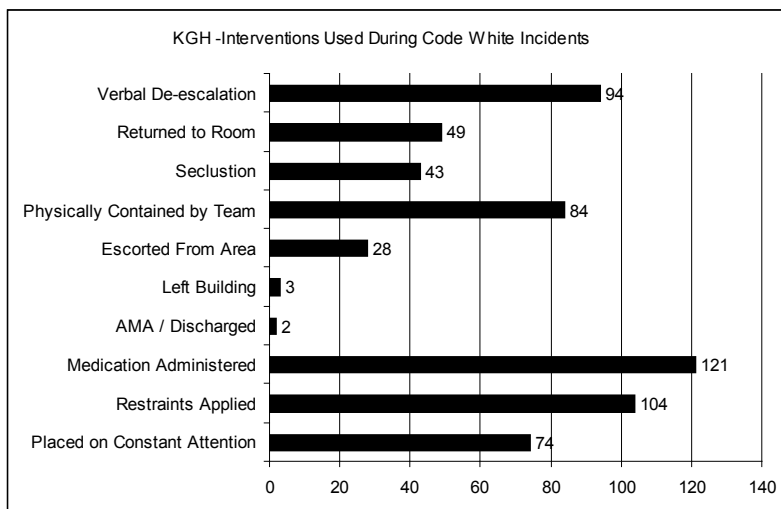
Possible contributing factors to the aggressor's behaviour

The following were identified as possible reasons or contributing factors to the individual's aggressive behaviour. Disorientation and confusion as well as mental health conditions were reported as the two main

contributing factors at all sites. Alcohol/drug intoxication or withdrawal as a contributing factor was surprisingly low at all sites.

Figure 7: Possible contributing factors to the aggressor's behaviour at KGH
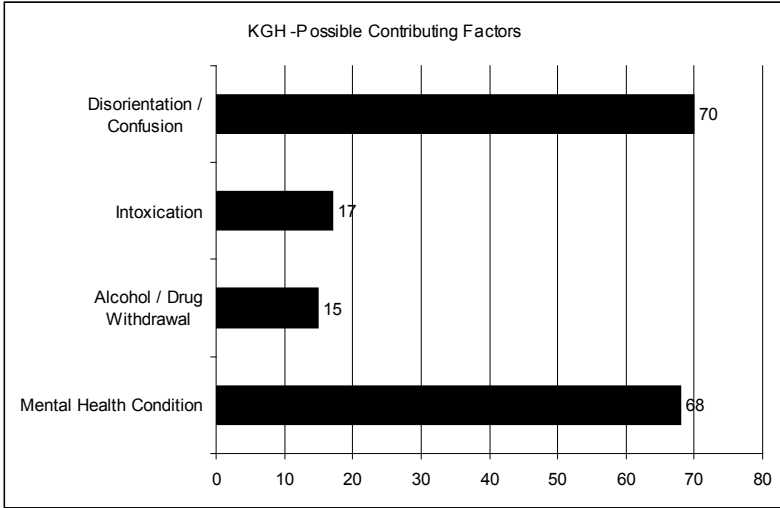
Number of staff injuries related to team response

KGH had 22 minor injuries reported from the 214 incidents, VJH had 5 reported from their 100 incidents and PRH reported 7 from their 117 incidents. Out of the 34 injures sustained by staff only one injury resulted in time loss with the remainder being minor injuries (primarily scratches, punches, kicks, being spit at, etc).

Percentage of interventions followed by staff wellness checks

The team response process outlines the need to conduct a quick wellness following a team intervention to ensure the responders are okay, and if not, appropriate medical and / or emotional support is provided and to determine successes and lessons learned from the interventions. KGH reported only 31% of incidents where followed up by a wellness check while VJH and PRH reported 14% and 59% respectively. Emphasizing the need for a post incident wellness check, is considered be a priority for all sites in 2010.

Number of active Response Team members at each site and the average attrition of members per year

	2008 # Team Members	# Left Team	% Left Team	2009 # Team Members	# Left Team	% Left Team
KGH	78	15	19	79	27	34
PRH	n/a	n/a	n/a	66	19	28
VJH	49	7	14	55	12	22
Average Attrition Rate	2008 17%			2009 28%		

This is an important factor to consider to properly budget for maintaining the program at each site. For our smaller regional hospitals, the initial estimate was a need for 50 staff / security trained responders and our larger tertiary sites a minimum of 65 trained members to ensure a minimum of 3-5 trained responders 24/7. Initially the budget included 10% attrition training to account for staff leaving or deciding not to participate on the team however the average percentage of attrition per site over 2 years was 23%. Thus the budget to maintain the response teams at each site was increased to accommodate 20% attrition. It is important to note that all sites currently have a wait list of staff members who have volunteered to become a Response Team member.

Refresher and Recertification Sessions
All members are expected to attend a four hour skill maintenance refresher session a maximum of 6 months from the time of the initial or re-certification training. The evaluation of the sessions indicated that staff perceives these essential to maintain their skill level and hence their confidence in participating in a team intervention. It is mandatory for all team response members to recertify annually for a full day recertification course. This course also enables members to.

Discussion and Conclusion

The initial beliefs and implementation steps that guided the formation of this program and specifically the Response Team component have greatly assisted in standardizing Interior Health's approach to violence prevention in our acute care sites. Key elements to enabling this process to succeed and be sustainable have been the following: the financial support initially from our provincial workers' compensation board (Worksafebc), the ability to prove a return on investment through statistical analysis of Team Response incident reports, the ongoing support for human and financial resources from the Interior Health Senior Executive Team, the support from provincial healthcare unions and, most importantly, the outstanding contributions from key stakeholders at the acute care site level, have been pivotal to the success of this program.

Testament to the impact an effective Response Team process can have on an acute care facility is summarized in the following quote from Penticton Regional Hospital Site Director, Maureen Thomson: "The VIP is a tremendous support to the frontline staff who need to feel supported by a structured, well functioning response team; a team that can assist them in addressing situations of violence that occur in the workplace. The return on investment is evident in the fact that we have been able to revive a Code White team that was falling apart. We now have a wait list for people who want to be on the team when, in the past, we couldn't get anyone to join. We had an overwhelming positive response to the training and we are constantly being asked by staff as to when additional sessions will be provided so that they too can attend. This has been a tremendous morale booster."

The VIP focus for the next two years specific to the violent incident Response Teams will be on development of our internal and provincial level VIP instructors, to support the three pilot sites and the five regional / tertiary hospitals that have implemented the program in 2009 and to further define Response Team processes at our smaller community level acute care hospitals.

In conclusion, by providing our regional/tertiary acute care facilities with an effective means to react "in the moment" to violent or potentially violent incidents and ensuring staff have the available resources and infrastructure to support the Personal Safety and Response Team education, these sites now have increased ability to intervene with violent or potentially violent situations and also have the necessary momentum to focus on the "upstream" proactive violence prevention initiatives. This will undoubtedly influence a culture of mutual respect and safety for all.

Acknowledgements

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Correspondence

Mrs Leslie Gamble
Interior Health Authority
31 1851 Kirschner Road
V1Y 4N7
Kelowna, B.C.,
Canada
+1 250-870-4782
leslie.gamble@interiorhealth.ca

Influence of clinical situations and ward organization on physical restraint in acute psychiatric hospital

Paper

Rosaria Di Lorenzo, Paola Ferri, Maria Ferrara, Mimmi Stefano, Sara Baraldi
MD-Mental Health Service, SPDC1-N.O.C.S.A.E, Baggiovara (Modena), Italy

Introduction

All handling, physical and mechanical methods applied to the patient in order to reduce his freedom of movement or access to his own body, was defined as physical restraints by Health Care Financing Administration in 1992 (Weick, 1992). This could range from isolation of the patient in an enclosed space, the so-called seclusion room (not in use in Italy), to immobilization of the patient by the staff physically restraining him or applying mechanical restraints, such as handcuffs or cotton or leather ties. According to the literature, the aim of physical restraint should be limited to self-injuring behaviour, to prevention of violent behaviour directed at others and to promoting control of symptoms such as anxiety, delusion, aggressiveness (Fisher, 1994; Gutheil, 1987). This procedure is widely accepted when all therapeutic restrictive measures for the patient who is a danger to himself or others have failed (Kallert, 2008). The frequency of physical restraint in acute psychiatric wards is not similar among the Western Countries according to the different culture and organization of Mental Health Service (Steinert et al., 2009). There is a total lack of controlled trials about the beneficial effects of coercive measures in patients with violent behaviour, since this clinical practice procedure has not been investigated by means of well-designed randomized studies, (Jarrett, Bowers, & Simpson, 2008; Murilidharan, & Fenton, 2006), as evidenced by Cochrane's systematic review of Sailas and Fenton (2000).

The aim of this work is to analyze the use of physical restraint in an acute psychiatric unit during a period of 5 years, in order to evidence the variables of patients, staff and ward related to this procedure.

Methods

The ward and procedure of physical restraints
The SPDC1 (Servizio Psichiatrico di Diagnosi e Cura 1) is a 15-inbed public acute psychiatric ward, located inside a General Hospital in Modena, which receives all patients from Modena and Castelfranco Emilia (population 250,000) affected by acute psychiatric diseases, compulsory or voluntary admitted (according to the "180" Italian Law).
In our ward, physical restraint consists of immobilizing the patient in bed (never in face-down position) through handcuffs, leg ties and vest, applied according to hospital procedure: 1. this procedure could be prescribed only by a physician when other control measures had failed, after evaluation of the patient's capacity to give his consent to treatment; 2. all staff had to focus attention on patient and staff safety, nurses had to continuously monitor the restrained patient and the physician had to re-evaluate every half hour the necessity for containment; 3. all above instructions and interventions had to be registered in the nurse restraint form and medical charts with the signature of each staff member, 4. during restraint, the necessary pharmacologic therapy and/or psychological support were prescribed with the aim to resolve the condition that had necessitated this procedure.

The sample: The sample was composed of all restrained patients admitted to SPDC1 of Modena from 1-1-2005 to 31-12-2009 (n=342).

The variables: The following variables, divided by year, were collected from medical charts and nurse restraint questionnaires and were relative to:
1) restrained patients' age, gender, and nationality.
2) admissions with physical restraint:
- diagnosis according to the Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR; American Psychiatric Association, 2000) criteria,

- voluntary state admission, with normal or altered state of consciousness due to intoxication or psycho-organic syndrome, or compulsory state admission, according to Italian Law "180";
3) physical restraints
- clinical motivations for restraints, divided into the following categories, according to the most frequent reasons registered in our ward and the literature indications (Kaltila-Heino et al., 2003): A) control of dangerous, violent or aggressive behaviour, B) prevention of damages or necessity of urgent therapy;
- time of restraints in comparison to the hospitalization day and to the three nursing shifts (Morning, from h 7 to h 13; Afternoon, from h 13 to h 20; Night, from h 20 to h 7)
- duration of restraints
- use of concomitant therapy
- the number of all admitted patients at the time of restraint use.

The analysis

From 1-1-2005 to 31-12-2009, we retrospectively collected data of restrained inpatients from medical and nurse sheets of all inpatient admitted to SPDC1 ward. We also collected data from a registry of restraints introduced in our clinical practice on the 1st January 2009.
Statistical analysis was performed in order to estimate the proportion of patients put in physical restraints in comparison to all patients admitted and to analyze the variables related to restraint use during the 5-year period, as shown in Table I and Table II (Kruskal-Wallis and Chi-Square tests) (Siegel, & Castellan, 1988).

We statistically analyzed the relationship between restraints and other variables; patients, admissions and staff. The following variables relative to restraints were statistically correlated: the motivations, the diagnosis, the state of admission and the day of hospitalization, the time of day (Chi square and Fisher tests) (Siegel, & Castellan, 1988). For the whole period, the number of physical restraints was statistically correlated to the number of all admitted patients at the moment this procedure was applied (Pearson correlation) (Armitage, & Berry, 1996).

In order to describe the strength of association or non-independence of the variables above regarding restraints, we measured the odds ratio (Mosteller, 1968) between restraint motivations (A: control of dangerous, violent or aggressive behaviour, B: prevention of damages or necessity of urgent therapy), restrained patient variables (age, gender, nationality), restraint procedure variables (time of restraints in comparison to the hospitalization day and to the three nursing shifts, duration of restraints, use of concomitant therapy) and state of admission (voluntary or compulsory).
The data was processed by the SAS System Program.

Results

As shown in Table I, the frequency of restrained patients was similar across the 5- year period but frequency of restrained male (p=0.045) and foreigner (p<0.001) patients increased in the last three years.

Table 1: Demographic data of restrained patients during the 5-year period

	2005	2006	2007	2008	2009
Restrained patients / all admitted patients (%)	49/385 (13)	61/394 (15)	78/380 (21)	80/451 (18)	74/487 (15)
Median age of restrained patients	43	47	40.5	35.5	46
Age ≤ 30 years	9 (18.4)	8 (13.1)	27 (33.8)	29 (36.3)	23 (31)
Age 31 − 40 years	13 (26.5)	16 (26.2)	13 (16.3)	20 (25.0)	18 (24)
Age 41 − 60 years	12 (24.5)	22 (36.1)	26 (32.5)	19 (23.8)	22 (29)
Age > 60 years	15 (30.6)	15 (24.6)	14 (17.5)	12 (15.0)	12 (16)
Sex of restrained patients. N (%)	F=23 (47) M=26 (53)	F=32 (52) M=29 (48)	F=32 (40) M=48 (60)	F=24 (30) M=56 (70)	F=30 (40) M=45 (60)
Nationality of restrained patients: N (%)	Italian=43 (88) UE=1 (2) Non-UE=5 (10)	Italian=57 (94) UE=2 (3) Non-UE=2 (3)	Italian=57 (73) UE=4 (5) Non-UE=17 (22)	Italian=58 (73) UE=2 (3) Non-UE=20 (24)	Italian=55 (73) UE=3 (4) Non-UE=17 (23)

Restraints were statistically significantly more frequently applied on night shifts (p<0.0001) and during the first 72 h of hospitalization (p<0.001) (Table 2). More than 50% of physical restraints were prescribed in compulsory admissions or in voluntary hospitalizations of patients with altered state of consciousness (Table 2).

Table 2: Physical restraint characteristics over the 5-year period

	2005	2006	2007	2008	2009
Restraints: N	229	243	310	200	233
Restraint admissions / all admissions (%)	60/540 (11)	68/501 (14)	89/503 (18)	86/581 (15)	84/656 (13)
Restraints per Patient (mean)	4.7	4	4	2.5	3.15
Restraints per Admission (mean)	3.8	3.6	3.5	2.3	2.8
Restraints in compulsory admissions: N (%)	107 (47)	70 (30)	136 (43)	79 (39)	120 (52)
Restraints in voluntary admissions (altered state of consciousness due to intoxication or psycho-organic syndrome): N (%)	67 (29)	91 (38)	53 (17)	50 (17)	30 (13)
Restraints in voluntary admissions (normal state of consciousness): N (%)	55 (24)	79 (33)	125 (40)	72 (36)	83 (36)
Restraints within 72 h of admission: N (%)	72 (31.3)	98 (40.8)	129 (41.1)	108 (53.7)	88 (38)
Restraints from 7h to 13h	37 (16)	51 (21)	68 (22)	31 (16)	32 (14)
Restraints from 13h to h 20h	66 (29)	74 (30)	78 (25)	43 (22)	73 (31)
Restraints from 20h to 7h	126 (55)	108 (49)	164 (53)	126 (63)	128 (55)

During the 5-year period, the most frequent diagnosis of restrained patients was "Schizophrenia and other Psychotic Disorders" (30%), followed by "Substance Abuse or Dependence and Substance induced Psychosis Disorders" (16%), as shown in Table 3.
In the whole observation period, the motivation of restraints, "control of aggressive behaviour", was statistically significant more frequent than "prevention of damages or necessity of a not postponed therapy" independently from diagnosis (p<0.0001).

Only the patients affected by " Dementia" and other cognitive disorders were statistically significantly more frequently restrained due to prevention of damages or necessity of urgent therapy, in comparison to the other diseases (Chi square test, p <.0001) (Table 3).

Table 3: Diagnosis and restraint motivation during the 5-year period: N (%)

	Restraint motivations		
	Motivation A	Motivation B	Total
Diagnoses of restrained patients	Control of dangerous violent or aggressive behaviour	Prevention of damages or necessity of urgent therapy	
Adjustment disorder, dysthymic disorder, anxiety disorder	70 (5.77)	21 (1.73)	91 (7.50)
Dementia, delirium, mental disorders due to a general medical condition	67 (5.52)	135 (11.13)	202 (16.65)
Anorexia nervosa	6 (0.49)	4 (0.33)	10 (0.82)
Mental retardation	44 (3.63)	2 (0.16)	46 (3.79)
Bipolar disorder	126 (10.39)	58 (4.78)	184 (15.17)
Personality disorders	146 (12.04)	28 (2.31)	174 (14.34)
Schizophrenia and other psychotic disorders	243 (20.03)	147 (12.12)	390 (32.15)
Substance-induced psychotic disorder and substance abuse or dependence	77 (6.35)	36 (2.97)	113 (9.32)
Other	3 (0.25)	0 (0.0)	3 (0.25)
Total	782 (64.47)	431 (35.53)	1213 (100)

Motivation A versus Motivation B, p<0.0001, Chi square

During nurse night shift, control of aggressiveness was the reason of restraint statistically significant more frequent (Chi square test, p <.0001) and duration of restraints was statistically significant more longer (>

4 hours) than during other nursing shifts (Chi square test, p <.0001). Physical restraints were associated in the 50 % of cases to a supplementary therapy: sedative therapy, antidote drugs, hydrating infusive therapy.

The following variables were associated to restraints adopted in order to control of aggressiveness with an odd ratio >1: young age (<30 years old), male gender, compulsory admission, normal state of consciousness, morning shift, early time of admission (< 2 days), concomitant therapy, short duration (< 1.5 h). Finally, this procedure was not influenced by ward overcrowding, because the number of inpatients admitted did not influenced the number of restraints.

Discussion and conclusions

The data of our 5-year analysis overlap those in the literature: physical restraint was most frequently applied in order to control the aggressive behaviour of psychotic patients (Monahan, 2003; Flannery, Rachlin, & Walker, 2002; Steinert, 2002; Winstanley, & Whittington, 2002; Nijman, 2002; Mignon et al., 2008). In our ward, physical restraint represented an usual tool of facing extreme clinical situations because its frequency and modality of applying was similar across the 5 years of observation, although it was adopted in acute situations. In fact, it was more frequently applied during the first days following admission with principle aim of controlling extreme situations of aggressive or dangerous behaviour in seriously ill patients.

In our study, patients affected by "Schizophrenia and other Psychotic Disorders" and "Substance Abuse or Dependence and Substance induced Psychosis Disorders" were more frequently restrained than others in order to control aggressive behaviour. This data, similar to data found in the literature, indirectly shows that paranoid delusions or excited mood are the most frequent clinical situations which induce behaviour so dangerous that mechanical containment could often be required in order to avoid harmful conditions for others or the patient himself (Mignon, 2008).

The restraint motivation relative to "control of aggressive behaviour" was also prevalent in the patients affected by "Personality Disorders" and "Adjustment Disorder and Dementia", suggesting that aggressiveness is a common symptom across many psychiatric disorders.

During the first days after admission, "the necessity of controlling an aggressive behaviour" was the prevalent reason for restraining, probably because the aggressiveness itself, which characterizes a wide range of psychiatric disorders, represented the prevalent reason for admission. During night shifts, physical restraints were more frequently applied in order to contain aggressive behaviour, the prevalent reason for restraint use during this period.
This data suggests that greater staff numbers, as found in the day shifts, could by itself be more efficient in containing patients, as noted by other Authors (Wynn, 2003). Otherwise, it could suggest that a lower care intensity and/or different staff organization could impact the application of this procedure.

Finally, in our ward, this procedure was not influenced by overcrowding, since its frequency did not change in accordance with the number of patients admitted. This data, different from the literature (Steinert, 2002; Winstanley, & Whittington, 2002; Nijman, 2002), could suggest that applying physical restraint was not related to overwhelming conditions such as an excessive number of patients.

The use of physical restraint was influenced by aggressive or dangerous behaviour of patients as well as the staff organization and attitude (it was more frequently applied during night shift due to aggressiveness), so we can presume that a better staff organization and a correct psychological training in facing aggressive patients could reduce it.

Considering ethical issue and clinical consequences of physical restraint, many strategies have been indicated in order to reduce this procedure. In our opinion, staff training should be based on a good awareness of one's own reactive feelings towards violent patients, in order to reduce the symmetric attitude which induces an escalation of aggressiveness. Moreover, as usually happened in lunatic asylums, routine containment, used as an alternative to a correct relational and pharmacological approach, could induce regressive behaviour in patients who can develop a psychological dependence on physical containment and, meantime, become more aggressive due to the punitive meaning of restraints. More studies are necessary to throw light on this controversial issue and to improve our professional practice.

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Correspondence

Mrs Rosaria Di Lorenzo
MD-Mental Health Service-SPDC1-N.O.C.S.A.E
via Giardini,
41100
Baggiovara (Modena)
Italy
+39 059 396 23 20
saradilorenzo1@alice.it

The Aggressive Behaviour Assessment Scale: An objective scale incorporating the ability to inflict physical harm

Paper

Lana Schultze, Leslie Gamble, Shannon Campbell, Lisa Davidson
Interior Health Authority, Kelowna, Canada

Abstract

In investigating specific violent incidents in Interior Health, a health authority in the province of British Columbia, Canada, it became clearly evident that minimal screening or comprehensive assessment of a patient's potential for violence was done upon admitting a patient to our facilities, during an escalating situation or following an aggressive incident. Thus a clinical working group, led by the Workplace Health Safety and Wellness Violence Intervention Program, embarked upon developing a tool that would not only assist staff with recognizing key aggressive indicators including the patient's ability to inflict physical harm, it would also provide an objective rating of the level of risk. The Aggressive Behaviour Assessment Scale (ABAS) categorizes the level of risk, high equaling a score of 15-20 and moderate equaling a score of 9-14 which could then be used to guide front line clinicians to available interventions within the health authority and/or the site to mitigate this level of risk.

The objectives for Interior Health to develop this tool were to; provide a tool that was not based on diagnosis but instead focused on four observable variables: emotional/mental status, observed behaviours, communication and ability to inflict physical harm, provide front line clinical staff with an efficient method to rate the level of risk involved with provision of care to an aggressive/violent patient, provide staff with an objective score to assist them in obtaining the necessary resources required to mitigate the risk, assist staff in defining aggression in a more accurate and legal manner rather than using phrases like "aggressive+++" and standardize the aggressive behaviour risk assessment process across Interior Health.

Introduction

The increase in violence in the health sector has been well documented in the literature as has the impact on staff and patient safety / well being, increased healthcare costs and staff retention. The ability of an organization to address this impact with a collaborative sustainable workplace violence program is central to the solution. As part of this process the literature promotes the use of a standardized patient risk assessment tool. [1, 2, 3, 4, 5, 6, 7, 8, 9, 10] Investigation of aggressive incidents within Interior Health revealed minimal screening or comprehensive assessment of a patient's potential for violence was documented upon admitting a patient to our facilities, during an escalating situation or following a violent incident. [11]As well progress notes in the patient chart often categorized the situation with subjective and poorly defined phrases such as "aggressive +++". Of the available patient assessment tools within Interior Health and further seen in the literature, these tools:

- tended to focus on clinical diagnosis with less emphasis on observable behaviours / characteristics making it difficult for staff to determine immediate interventions,
- were often lengthy to complete and therefore were rarely being used
- did not associate a level of risk to the observed potential behaviours / characteristics again making it more difficult to clearly define interventions
- did not take into account the ability of the aggressor to inflict physical harm on staff.

Interior Health's response to the recognized need for a practical, easy-to-use patient assessment tool which would direct staff interventions options has been the development of the Aggressive Behaviour Assessment Scale (ABAS). The ABAS is a quick effective tool which allows frontline clinical staff to assess patient aggression by observed behaviours not their diagnosis. It consists of 4 four variables. The four observable variables are mental status, behaviours, communication and ability to inflict physical harm. Within each

variable there are five different categories rated with a numerical value from 1 (minimal) to 5 (maximum). Each category has a list of behaviours that the frontline staff member ticks if applicable. A person with a score of 15-20 is a high risk and 9-14 is a moderate risk. The result is that front line clinical staff are provided with an efficient method to rate the level of risk involved with provision of care to an aggressive patient. The risk level is then used to direct staff to a list of suggested interventions and resources which will help to mitigate their risk. Their individual variable and overall score is tracked hourly if they are deemed a high risk and is monitored for effectiveness. The ABAS, interventions and resources are located in an Aggressive Behaviour Toolkit available on each unit throughout the hospital or electronically.

The anticipated benefits of the ABAS for Interior Health staff and patients are as follows. The ABAS assists staff in better defining patient aggression / violence allowing compliance with medical / legal charting requirements, it directly links the identified risk level to available interventions at the site, it increases the ability to communicate risk amongst staff within the unit and throughout the hospital when transferring between units and, once standardized across Interior Health, it will allow a better understanding of associated risk when patients are transferring amongst facilities and, finally, it provides staff with justification for specific interventions resources and, in some cases, application of advanced options such as use of seclusion rooms, rapid tranquilization medications, mechanical restraints and aggressive / violent behaviour electronic alert. This final benefit is critical to ensuring that staff address their ethical responsibilities in applying these advanced interventions options and assists our organization in addressing the concerns reflected in the literature surrounding restraint use and patient rights / confidentiality. [12, 13, 14, 15].

Background

The Aggressive Behaviour Assessment Scale's working group, consisting of frontline clinical staff representation from four acute care hospitals and the Violence Intervention Program (VIP) Research Assistant and Coordinator, was formed in January 2009. Prior to the group meeting, the VIP Research Assistant conducted an extensive review of all existing assessment tools within Interior Health and the province of British Columbia as well as tools sourced from the literature. From these resources, she narrowed down key assessments that had components that addressed the above noted needs and brought these to the first of three two day working group meetings. The group developed clear objectives for the tool and then focused on key components from each of these tools which would serve as a base for the ABAS. These objectives included the need to:

- provide a tool that was not based on diagnosis but instead focused on four observable variables: emotional/mental status, observed behaviours, communication and ability to inflict physical harm
- provide front line clinical staff with an efficient method to rate the level of risk involved with provision of care to an aggressive/violent patient
- provide staff with an objective score to assist them in obtaining the necessary resources required to mitigate the risk
- assist staff in defining aggression in a more accurate and legal manner rather than using phrases like "aggressive+++"
- standardize the aggressive behaviour risk assessment process across Interior Health

Several iterations of the ABAS and comprehensive critique through a clinical and safety lens enabled the group produce a draft that was ready for review by stakeholders from outside the working group. The draft ABAS then went through a lengthy stakeholder consultation from March – December 2009. This review from all levels of the organization which included frontline staff, managers and physicians from Emergency Departments, Psychiatric Units and Medical/Surgical Units, representatives from the following departments/committees within Interior Health: Professional Practice Office, Risk Management, Nursing Union, Quality Patient Safety, Ethics Committee, and the Least Restraint Policy Development Committee. The Aggressive Behaviour Assessment Scale was then trialed at four acute care hospitals and was again modified using this clinical feedback. It was formally endorsed by the organization as an acute care standard allowing implementation at Kelowna General Hospital-KGH (a 340 bed tertiary acute care hospital) in January/February 2010, Penticton Regional Hospital-PRH (a 129 regional acute care hospital) in February/March 2010 and Vernon Jubilee Hospital-VJH (a 140 bed regional acute care hospital) in June/ July 2010.

A requirement further of the ABAS implementation was assurance from each site that a potential for violence screening process would be incorporated into the sites nursing admission forms and daily nursing assessment forms. This was completed at all sites. As well a screening tool was incorporated into Interior Health Nursing Emergency Department Patient Admission forms. These screening tools would then direct staff to complete the ABAS if indicated.

Discussion

The objectives outlined by the working group responsible to develop the Aggressive Behaviour Assessment Scale have been met. While the initial informal feedback from hospital staff and management at the initial pilot sites has been positive, it is now imperative that this tool be formally evaluated. A six month post implementation evaluation will be conducted at each site which will include:

- Chart audits of patients involved in violent incidents to determine if the ABAS was completed, if it was completed as per the guidelines, if there was documented use of interventions linked to the ABAS score, if subsequent charting of witnessed behaviour was consistent with medical/legal charting requirements and finally if the tool was valid in accurately assessed the level of risk.
- Staff and manager questionnaires to determine perception of the benefits and ease of use of the ABAS using a 10 point Likert scale.

This review will then provide the concrete support outlined in the five objectives of the Aggressive Behaviour Assessment Scale.

Conclusion

The development and implementation of the Aggressive Behaviour Assessment Scale is our health authorities attempt to provide staff with a patient assessment tool that more accurately describes the observed behaviours / characteristics indicating a patient's potential for violence. It is our belief that it meets the objectives identified by the Interior Health working group tasked with development of this tool. It is a key component of the Interior Health's Aggressive Behaviour Toolkit as it guides staff to determine the intervention strategies available and pertinent to the assessed level of risk. These intervention strategies with the associated information, clinical protocols and documentation forms comprise the main content of this toolkit.

While the Aggressive Behaviour Assessment Scale is in its infancy and requires more formal evaluation feedback, as is planned in the six month post implementation evaluation, key stakeholders within our organization are strongly endorsing its use and are making its completion a requirement for use of advanced intervention options in our acute care facilities. Interior Health is optimistic that this tool will assist our front line staff in mitigating the risk of violence to our staff and patients.

Acknowledgements

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Correspondence

Mrs Lana Schultze
Interior Health Authority
31 1851 Kirschner Road
V1Y 4N7
Kelowna, B.C.,
Canada
+1 250870 47 82
lana.schultze@interiorhealth.ca

The Aggressive Behaviour Toolkit: Infrastructure required to support a violence prevention program in acute care

Paper

Leslie Gamble, Lana Schultze, Shannon Campbell
Interior Health Authority, Kelowna, Canada

Abstract

Interior Health, a health region in the province of BC, Canada, embarked on developing a new violence intervention program in 2007. The initial stage of development was spent conducting provincial, national and international research into effective methods to assess, communicate and mitigate violence in healthcare. The results indicated that there were significant opportunities for our health region to develop innovative tools and processes that were essential to support our new staff violence prevention education platform. Over the following 2 years front line clinical staff and physician working groups, in conjunction with injury prevention specialists, have developed the following components of this new toolkit:
- Aggressive Behaviour Assessment Scale (which incorporates observed patient behavior, emotional and communication status with the physical ability to inflict harm),
- Medication Guidelines for Adult, Geriatric and Pediatric Patients Suffering from Severe Agitation / Aggression,
- Advanced Restraint (Rapid Tranquilization, Mechanical Restraints, Seclusion) Documentation Tool and Processes,
- AGG (aggressive) Alert Electronic Application Process and Physical Tools,
- Code White (violent incident response) Process and Team Response Information,
- Police Liaison Process,
- Procedure to Expedite Transfer of Aggressive Patients to a Regional or Tertiary Care facility,
- Site Specific Procedures (i.e. Search and Secure Belongings, Application for and use of Constant Care Providers),
- Pertinent Clinical Resources Including Medical Legal Charting Tips for Charting Aggressive/violent Incidents and Universal Care Plan Tips for Safe Provision of Care to Aggressive/Violence Individuals.

The Aggressive Behavior Toolkit is a practical resource binder that enables front line clinical staff with quick access to the available assessment, communication and mitigation tools in our health region to prevent and manage aggression/violence. The toolkit is or will soon be available on all inpatient acute care units in our health region in both a physical and on-line version.

Correspondence

Mrs Leslie Gamble
Interior Health Authority
31 1851 Kirschner Road
V1Y 4N7
Kelowna, B.C.,
Canada
+1 250 87047 82
leslie.gamble@interiorhealth.ca

Optimizing staff and patient safety through the environmental design of psychiatric units and emergency department psychiatric areas

Workshop

Leslie Gamble
Interior Health Authority, Kelowna, Canada

Abstract

In 2007, it was evident that the province of B.C., Canada had experienced an alarming increase in the number of violence-related incidents and patient self-harm incidents in inpatient psychiatric areas. Thus, during the functional and space programming stage of a new acute Psychiatric Care unit and two new Emergency Departments in the interior of the province, it was deemed essential that Interior Health explore the impact the built environment had on these issues. A literature review, post occupancy reviews of a new 12 bed adolescent psychiatric unit and a 44 bed tertiary care psychiatric facility, pre-design staff and patient surveys of a new Emergency Department, multiple ergonomic assessments of Psychiatric and Emergency departments within our health region and consultation with many healthcare providers and architects within the western Canada was conducted and design recommendations were made resulting in the 2006 article "Facility design considerations to increase patient and staff safety in mental health facilities" . Further construction and product research was conducted into the design of the walls, doors, door frames and locking mechanisms for seclusion/observation rooms in 2009, after five incidents were reported in the province in which seclusion room doors, door frames or door locking mechanisms were dislodged and forcibly opened by distraught patients. As well, Interior Health the ergonomic consultant had three requests to determine effective courtyard fencing resulting in research into this area. The outcome, of the work completed in 2006 and expanded upon in 2009, is a comprehensive list of facility design features for each room/area in an inpatient unit or Emergency Department psychiatric area which should be considered in the design of any newly built or renovated area. This paper will address the 2009 additions only.

Introduction

It was evident in researching for the 2006 paper titled "Facility design considerations to increase patient and staff safety in mental health facilities" [1] that not only was there an increase in violent incidents in mental health settings and a need for to look at how facility design features contributed to violent incidents to both to patients and staff in mental health areas, there were limited resources available to assist design teams to create functional and safe acute care mental health environments. By identifying this gap, Interior Health saw great opportunity to better define design features that should be considered when designing these spaces. This 2006 paper outlines the considerations for all rooms in an acute mental health facility.

In 2009, this work was expanded upon after our health authority experienced a critical incident, in which a distraught patient in an emergency department seclusion room forcefully damaged the magnetic lock, buckled the door and loosened the door frame enabling him to leave the room and run freely in the Emergency Department. This action not only created commotion in the area but it also created potential for physical and emotional injury to staff, patients and others. Further investigation indicated that there were several other incidents in our province in the previous two years. Four other seclusion room doors had been forcefully dislodged or opened, doors with one point of contact locking mechanism had buckled on either side of the lock and doors controlled electronically had opened during level 1 and 2 fire alarms.

Another design feature that was not researched fully in 2006 was the design of exterior courtyards located off mental health units. Specific requests to assist sites with determining appropriate fencing for these spaces highlighted a need to further research the functional requirements and effective design features of these spaces as well.

Methods

Systematic review of the literature

For the expanded work on seclusion room and courtyard design features, further national and international literature from 2006 to recent publications was reviewed. Further research within our province indicated a continued increase in the prevalence of violence in healthcare as 80% of healthcare workers surveyed stated they had experienced violence in their workplace [2] and the associated financial and human resources costs associated with these events were also increasing [3].

Specific articles that proved very helpful in the creation of these 2009 additions were the updated 2008 version of the "Guidelines for the built environment of behavioral health facilities" [4] and again the 2005 article titled "The effect of the built and natural environment of a mental health unit on mental health outcomes and the quality of life of the patients, the staff and the visitors."[5] The 2000 British Columbia Observation Room Standards [6] also acted as a base to work from but did not incorporate sufficient design details identified as areas of concern. (e.g. door/door frame construction and locking mechanisms).

Staff, physician, facility planners and architect consultation

Extensive consultation was completed for the initial 2006 work as outlined in that paper.

The majority of these design considerations were gathered from many interviews with front line staff in our emergency and psychiatric units who had frequently assisted patients requiring seclusion. As well a formal working group at Penticton Regional Hospital which consisted of psychiatric nurses, registered nurses, area team leader and plant maintenance carpentry staff was formed with frequent consults from March 2008 to November 2008.

Ergonomic assessments

The ergonomic consultant performed an ergonomic review of the physical environment of 3 psychiatric facilities in our region, was on the design development and equipment selection team of the adolescent psychiatric unit, was asked to review end stage design development drawings and assist with equipment selection of the tertiary care facility, conducted an ergonomic review of the Penticton Regional Hospital Psychiatric and Emergency seclusion rooms and, as a member of the Interior Health Facility Planning Core Planning Team, has provided ergonomic input into a psychiatric suite planned in the renovation to the region's largest emergency department and a new psychiatric unit.

Results

Design considerations for Seclusion Rooms

Site Lines - staff must be able to view all angles of the room. This may be feasible from the viewing window and/or the nursing security monitor. Rationale – patients have hidden behind blind spots in rooms decreasing staff ability to monitor.

- Door, door frame, door hinge, locking mechanism and windows - must be able to withstand forceful kicking/body slamming
- door should not buckle as is evident with single locking mechanism and a non-insulated door,
- door frame must be constructed and adhered to the walls in such a manner that it can not be loosened
- door locking mechanism must be 3 point (with no point going into the floor) and lock simultaneously
- Door lock must not release when a level 1 or 2 fire alarm, or in a power outage; strongly recommend manual locking system with site protocol for unlocking procedure in the event of a fire or other catastrophic event (this was approved in IH facilities by the fire department)
- Door lock must not be card accessed
- Door lock must be easy for staff to lock and unlock – 3 point simultaneously locking essential
- Door window must:
- allow viewing of as much of the room as possible by staff while maintaining pt privacy
- be close to the recommended size 18" wide by 18" high as identified by working group in PRH Psychiatry
- must withstand forceful kicking/punching
- be encase in a tamperproof manner (e.g. pick proof caulking)

Product / construction recommendations

Door construction:

Option 1: An ultra heavy duty construction 3 ply LVL core for high impact door interior use similar to Baillargeon Model number 7600-ME . Dimensions = 48" wide x 84" high x 2" thick

Option 2: A high security solid 1219 (48") X 54mm thick (2 ¼") solid hardwood core manufactured from high density hardwood (min 800Kg M); all hardwood joints to be finger jointed in length and edge; doorset reference 'Maudsley product code S-11375. Door finished with plywood and MDF skins, hardwood lipped

to all edges, with an overall finish of 54 (2¼"). (www.surelockmcgillgroup.com/sbd/product/seclusionMAIN.HTML)

Door finish: should be clear, durable sprayed on lacquer which meets all infection control standards.

Door hinge: stainless steel piano hinge or five duty 5-knuckle security hinges with stainless steel centre pin and welded ends; preventing tampering to the hinge pin. All hinge screws in stainless steel, countersunk with security screws similar to pin torx. (www.surelockmcgillgroup.co.uk); door swing out to a clear 180 degrees

Door frame: welded one-piece steel frame 14GA galvanized welded and factory primed with six (1/2") wall anchors at equal distance; top fixing positioned at 190mm down from the top and bottom fixing located 90mm up from the bottom.

Door locking mechanism and door handle: must have multiple bolting/locking system securing the door at the top, bottom and centre that simultaneously lock door (similar to Surelock mortice fitted locking system (www.surelockmcgillgroup.com/sbd/products/seclusionPages/seclusion2.html). There should be no locking points going into the finished floor as these can create hygiene problems (difficult to clean receiving hole in floor) and operational problems (items get clogged in hole making it difficult to lock door). All locking points, as detailed in the frame specification, should be secured into a dedicated strike plate with a minimum of 2No. fixing points and a minimum thickness of 4mm. The locking bolts should have a minimum of 25mm throw. The locking bolts should have a minimum diameter of 15mm and be case hardened steel. External operation by an anti-ligature guarded pull handle and key lockable with no internal operation. Locking system must be compatible with site key mechanism (cylinder core). Locking bolts can also be set up to engage automatically upon door closure.

Door Window and Privacy Screen/Blind recommendations: a vision panel with an integral privacy screen that is key operated (similar to Vistamatic Vision Panel). Internal blinds and other options not acceptable due to durability issues. The vision panel unit should be set into the door leaving a flush rounded finish internally with a heavy duty hardwood fixed frame externally mounted with security screws similar to pin torx® screws. Each side of the vision panel should be a minimum ½" laminate or polycarbonate.

Rationale for Door Specifications: all components of the door must be able to withstand excessive force as can be applied by distraught patients. Trials of the vision panel systems in the United Kingdom indicate these panels are very durable and require little maintenance. It also provides the privacy without requiring internal blinds, which have created significant maintenance issues, or curtains, which tend to get ripped off the wall. The solid wood door enables the locking mechanisms to be embedded in the wood which decreases noise generation. There are similar multiple point locking mechanisms on the market however the Surelock locking system was the only one that met all this criteria: could be embedded in the door, making the door less jail like in appearance, had a bottom locking mechanism that does not go into the floor making it more durable and hygienic.

Walls composition, protection and privacy rating - optimal to have concrete blocks for newly constructed areas or plywood walls with soft wall padding to 8'H (see details following) for renovated areas; if soft wall padding is not applied, two layers of ¾ plywood topped with one layer of 5/8 drywall is recommended; ensure room has an acoustical confidential privacy rating (STD=45-55dB) [22] which can be enhanced by use of fiberglass batting in the wall space *Rationale*: increased safety for distraught patient; respectful appearance; privacy rating will ensure patient has adequate privacy and that other patients are not as bothered by behavioral outbursts. Enables walls to withstand forceful kicking/body slamming to prevent need for constant repair.

Soft wall padding: wall padding recommended for all Psychiatric and high use Emergency seclusion rooms in regional level hospitals. Protective padding material shall be a synthetic resinous material (similar to Gold Medal Safety Padding as manufactured by Marathon Engineering Corporation. Substitutions of a closed cell polyvinyl chloride or other types of polyvinyl chloride surfacing material will not be permitted. In addition to meeting the minimum physical properties when cured, protective padding must contain a flame spread and smoke index which when tested in accordance with ASTM E84 is given a class A fire rating or outside North America, rating with same standards as Class A. Padding must also conform to the following criteria.

- Weight is approximately 5 pounds per square foot
- Tensile strength range 300 P.S.I. minimum ASTM D412
- Temperature stability – unaffected from 20 degrees F to 120 degrees F
- Moisture absorption 0.8% to 1.05% by weight
- Compression set 90% recovery after 72 hours
- Compression properties 30 PSI to 70 PSI at 50% modulus

- Elongation at break 150% typical ASTM D412
- Fungus resistance complete

Rationale for Soft Wall Padding: increased safety for distraught patients who have, in the past, been known to hit seclusion room walls with limbs or their heads. This may result in less need or less dosage of sedative medication as the patient can work off anger without hurting themselves; increased safety for staff trying to get a distraught patient into these rooms (e.g. Code White Response team performing a patient containment procedure). As well, the padding is respectful looking and durable.

Urinal and sink - stainless steel; recommend product similar to the Willoughby Industries Model # 1806 – Anti-suicide combination lavatory; water control outside room in an easily accessible spot and in a tamper proof enclosure for staff to easily access in an urgent situation *Rationale*: distressed patient have clogged toilets causing significant flooding inside the room; water shut off valve is often not accessible making the water damage and clean up more prominent.

Floor Drain - floor drain with trap primer required for effective cleaning of room and toilet overflow; maximum 2° sloped gradient with drain placed opposite where mattress will lie; tamperproof drain cover *Rationale*: patient have blocked toilets causing overflow and have spread their feces on the walls etc which has to be cleaned urgently; gradual floor slope and drain placement will ensure patient will be able to lie relatively flat.

Lighting - Provide natural lighting tempered shatterproof safety glass window situated at 7' h (to prevent damage to the window); provide warm medium bright general artificial lighting; provide dual light levels that can be switched from outside the room to allow staff to increase lighting level to accommodate patient requests or care needs. Housing for light fixtures must be tamperproof, inset and installed with secure screws. *Rationale*: Natural lighting is calming to most people [16]. Warm medium bright general lighting promotes relaxation [18]. Glass block substitution for a window is not recommended as patients have been able to break these at an Interior Health Acute Psychiatric Center.

Sprinklers - tamperproof institutional sprinkler heads installed with tamper-resistant screws and made to break –away under a 50lb load. *Rationale*: More difficult to break and to hang anything from.

Smoke Detector - tamper resistant but not caged *Rationale*: caging these discouraged due to hanging risk.

Ceilings – non accessible solid gypsum board ceiling with access panels located outside seclusion room; for increased privacy rating in rooms, acoustic tiling can be adhered to the gypsum board; optimal to have full wall plenum built from ceiling to floor above *Rationale*: patients have hidden drugs and weapons in ceiling area and have hung themselves from pipes above tiles; noise generation from seclusion rooms can impact well being of other patients and staff in the area
HVAC grilles – grilles must have small perforations or mesh in behind grill; must be installed with tamper resistant screws. *Rationale*: limits hanging potential.

Video Surveillance - essential to have a view of the entire room including toilet/sink [4,9]. Optimal to have camera view as wide angle as possible and to have a small wall mounted monitor outside door (accessible only to staff via a swipe care or keypad access) and a main monitor at the nursing station *Rationale*: staff must be able to fully monitor the patient at all times; door monitor can notify staff where patient is in the room and the patient's activities just before they enter the room (if not visible through door window); wide angle captures more area increasing staffs' ability to observe patients.

Intercom - essential to have intercom access to patient both from the nursing station and from just outside the seclusion room *Rationale*: staff can notify the patient that they will be coming in or try to deescalate aggressive behaviours prior to entering the room.

Wall color - natural wall colors *Rationale*: These are proven to be calming to most people.[7]

Mattress - must have no metal parts Rationale: patients have used the metal parts as weapons or for self harm activities.

Exterior courtyards
Decking – must be composed of fire resistant material, easy to clean and not easy to remove Rationale: in one new facility the decking was composed of large squares of material that patients were able to pull off and throw; ease of cleaning required especially if smoking permitted in area

Lighting – must have tamper and weather proof exterior lighting *Rationale*: patient comfort and staff observation needs.

Plant/foliage – provision of plants or shrubs that when full grown can not hide a person from view; all plants must be non-poisonous and non-toxic

Furniture – optimal to be able to secure deck furniture to deck *Rationale*: patients have stacked furniture to assist in elopement efforts or have thrown deck furniture

Fencing – 9'6" minimum height; minimal to no spacing between boards or other building materials (e.g. use of chain link fencing, security fencing with openings more than 1/8 inch or wrought iron decorative fencing with the standard vertical beams supported by horizontal beams; controlled fire evacuation route via inclusion of a solid gate or door ; locking mechanism to be carefully selected to ensure it can be quickly unlocked in the event of a fire but secure at all other times; *Rationale*: 9'6" is equivalent to the overhead reaching height of a man in the ninety fifth percentile range for height plus 18" jumping height; limited spacing impedes a patient's ability to climb the fence, attach an object for hanging or allow visitors to pass restricted substances through the opening in the fence.

Discussion

It was evident in the literature review that while there are a few key references available to architects and facility design teams on the design features that enhance staff and patient safety, they did not address all the staff and ergonomic concerns identified in Interior Health's review of psychiatric treatment areas. With the increased prevalence of injuries to healthcare workers as a result of violent outbursts by patients and of self harm injuries to inpatients, Interior Health saw an opportunity to enhance the design considerations of these treatment areas.

As with the environmental recommendations provided by the National Collaborating Center for Nursing [7], these expanded considerations were reached by formal consensus among the many multidisciplinary healthcare workers from review by healthcare architects, from the few detailed reference documents found in the literature review and from the ergonomic analysis of these rooms / areas. A six month post occupancy survey of staff perception [8] conducted in one Interior Health facility which incorporated many of these considerations incorporated in the initial work completed in 2006, resulted in 100% of the staff perceiving the design of the unit contributed to both patent and staff safety. As well an informal review of staff perception of our pilot seclusion room indicated staff were very satisfied with the final design with the exception of the following recommendations:

- Need for less "confusing" door lock. This concern has since been resolved.
- More attention to in room camera specifications (pan, zoom, night vision)
- Electronic solenoid for water shut off as opposed to manual.

Conclusion

It is Interior Health's hope that these design considerations will be of value to architects, planners and staff tasked with designing newly built or renovated psychiatric treatment spaces. Long term evaluation or these design considerations is recommended to determine the effectiveness of these safety considerations on staff and patient injury rates, on staff and patient perceptions of safety and well-being and on future retrofit costs over a given time frame. These facility design considerations should be considered dynamic with continued attention to updating and refining them as more research and psychiatric facility planning is completed.

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Correspondence

Mrs Leslie Gamble
Interior Health Authority
31 1851 Kirschner Road
V1Y 4N7
Kelowna, B.C.,
Canada
+1 250 870 47 82
leslie.gamble@interiorhealth.ca

Restraint reduction through the use of low entry nursing beds (LEB) on a geronto-psychiatric unit

Poster

Petra Kurka-Pröglhöf, Petra Weiland-Fiedler, Sabine Krause, Vera Pfersmann
SMZ-Otto Wagner Hospital, Vienna, Austria

Abstract

Background

The use of restraints as an intervention in the management of acute mental distress and prevention of injuries in psychiatry wards is strictly regulated by the Austrian law. It is stated that restraint practices are only permitted for emergency situations when there is imminent risk of physical harm to self or others. Geronto-psychiatric symptoms such as confusion, disorientation, agitation, hyperactivity and physical exhaustion lead to a higher risk of accidental falls and injury. This is the most common cause of use of coercive treatment. Therefore mechanical restraints such as bed straps or special psychiatric intensive beds (net bed) are used to help to prevent dangerous behaviour and self harm. These coercive interventions have serious physical and psychological consequences such as reduction of personal mobility or loss of dignity. At the geriatric unit of the 3rd Psychiatric Department of the Otto Wagner Hospital in Vienna/Austria low entry electric nursing beds (LEB) were implemented that adjust from 22cm to 62cm and were used as an alternative injury prevention.

Study aim

The purpose of the study was to identify if the use of LEB had an impact on the reduction of coercive interventions.

Methods

From December 2008 until December 2009 a retrospective review of the number of perceived coercion in our geronto-psychiatric ward was carried out. During this time period two groups suffering from dementia were investigated. One group was referred to a low entry bed (LEB), the other was admitted to an ordinary nursing bed. Both groups were matched by diagnosis, gender, age and length of the stay. Of these participants all coercive interventions were collected in a dataset and statistically analyzed.

Results

The total number of physical coercive interventions could be decreased by 44 % among patients lying in the LEB. While only 20% of the patients in the LEB needed to be restrained during their stay, 46% of the patients in the ordinary nursing bed had to undergo a coercive intervention. The most common coercive intervention was the psychiatric intensive bed (net bed). 16% of the patients in the LEB were coerced sometime into a net bed in comparison to 32% of the patients regular lying in an ordinary nursing bed who had times when they were forced to stay in the net bed. It was also assessed that the duration of a restriction episode could be reduced by 15.5% within the LEB group.

Conclusion

The use of LEB turned out to enhance the clinical care and was highly effective by reducing coercive interventions.

Correspondence

Mrs Petra Kurka-Pröglhöf
SMZ-Otto Wagner Hospital
Baumgartner Höhe 1
1145
Vienna
Austria
+43 1 91060 21932
petra.kurka-proeglhoef@wienkav.at

Translating workplace violence hazard assessment and program impact methods

Workshop

Kathleen McPhaul, Matthew London, Jane Lipscomb
University of Maryland School of Nursing, Baltimore, USA

Abstract

Background

Participatory action research (PAR) designs are contributing new insights into workplace violence prevention by increasing the relevance and usefulness of research data. Several studies strongly suggest that a comprehensive and participatory approach in healthcare is necessary to reduce workplace violence. Regulatory agencies, employers, and workers require sound evidence in order to commit resources to workplace violence prevention programs.

Theoretical nodel

Our model explains workplace violence prevention via these primary domains: the healthcare and political systems, the caregiving work environment, and the characteristics of the patient population. The healthcare and political systems include the availability of resources for patient care, the dominance of the patient safety and patient rights culture within the system, and specific policies and regulations that impact safety such as elimination of seclusion and restraint or a state workplace violence prevention program law. The caregiving work environment includes elements such as: staffing levels; levels of overtime, especially mandatory overtime; the experience and training of the staff in handling violent situations; the job demands and pace of work; and the safety climate, including the perception that your supervisor cares about your safety and as well as about the patients/clients. High risk patients include those with a prior history of violent behavior, those that are dually diagnosed with a substance abuse disorder and a mental illness, and those who are under the influence of alcohol or other mind altering drugs.

Design and methods

In this paper we report on a non-experimental evaluation of a workplace violence prevention project conducted in a state-run system of 13 residential addiction treatment facilities. The use of a mixed method study design was employed to evaluate the impact of comprehensive violence prevention programs in these complex and dynamic settings. Our previous research has demonstrated that individual qualitative or quantitative measures may not adequately assess risk nor program impact. Collectively, however, a mix of qualitative and quantitative measures contributes important new information to the prevention of violence in high risk health and social service settings.

Findings

Multiple research methods for assessing violence and benchmarking program impact will be discussed from the standpoint of translating these methods into pragmatic approaches that employers can use in workplace violence prevention programming. Key informant interviews, staff focus groups, environmental evaluations, survey measures, and an organizational and program audit will be discussed. Structural approaches such as project advisory groups and health and safety committees will also be discussed. Workshop Format: This ninety minute workshop will review the specific recommendations from this study. The risk assessment methods will be discussed and applied in an interactive approach with the audience. Worksheets and case exercises will be used to apply the findings from this study to settings where audience participants work.

Correspondence

Mrs Kathleen McPhaul
University of Maryland School of Nursing
655 Lombard Street
21201
Baltimore
USA
+1 410 0935 01 80
mcphaul@son.umaryland.edu

Clinical Practice Guidelines for violence risk assessment in mental health triage: An evidence-based approach

Paper

Natisha Sands, Stephen Elsom
Deakin University, Geelong, Australia

Abstract

Background

Mental Health Triage services are integral to Australian health service delivery, in that they provide the primary interface between the community and health services. At present, violence risk assessment at triage lacks a suitable evidence base and clear guidelines.

Aim

The aim of this project was to identify the highest level of evidence for risk factors for service-user for violence, and from this evidence develop Clinical Practice Guidelines (CPG) to support triage clinicians in violence prevention.

Method

The project utilised Australian National Health and Medical Research Council methodology for developing Clinical Practice Guidelines. This method involved a systematic review, as well as input from two expert panels of triage clinicians and consumers. The guideline was then formally piloted tested by triage nurses from two major metropolitan hospitals in Melbourne.

Results

The Systematic review established the highest level of evidence for risk factors for service user violence. Three domains of risk were identified in the study: Patient risk factors, environmental risk factors, and staff risk factors. A CPG and an integrated model for violence prevention were developed from these findings. This presentation focuses on presenting the mental health related risk factors for consumer violence

Funding body

Correspondence

Mrs Natisha Sands
Deakin University
Geelong Waterfront
3217
Geelong
Australia
+61 3 5227 8417
natisha.sands@deakin.edu.au

Violence against physicians: An evaluation of the strategies and initiatives introduced in Israel

Paper

Malke Borow. Leah Wapner
Israeli Medical Association, Ramat Gan, Israel

Introduction

Violence, besides its destructive social effects, can have numerous health effects on its victims: from gastrointestinal disorders and psychomatic symptoms to chronic pain, acute injury or even death. Violence against health workers in general, and doctors in particular, is particularly insidious: not only does it affect the health worker involved but it impacts the system by affecting the quality of the working environment and, therefore, the quality of care received by patients.

The reasons for the increase in violence against health professionals are several. Patients no longer view the doctor as infallible saviours. Instead, the doctor is viewed as a messenger of the system and, therefore, as the cause of all the system's problems. The physician becomes society's scapegoat for all that is wrong with modern medicine. With health care costs rising and technology becoming increasingly expensive, doctors may have to tell patients that the medicine they need is not covered by insurance or authorized by their HMO or sick fund. In addition, the ever-growing manpower shortage in hospitals and clinics results in overburdened doctors and longer waiting times. All of these factors can result in anger directed towards the doctor.

Strategies to deal with violence in the health sector

Several studies within Israel have identified the most common triggers for acts of violence in the health sector as long waiting times and dissatisfaction with the treatment provided. (CarmiIluz et al 2005; Landua 2004; Derazon et al 1999) Such studies also determine that a multi-faceted approach is required in order to address the issue of violence in the health sector, one that covers such issues as: legislation, police involvement and security in health institutions, situational factors such as overcrowding in waiting rooms and training of staff members in dealing with confrontational situations. The studies also recommend increased support for physicians and health care workers following attacks, the addition of services intended to accompany the physician following violent encounters, improved recording procedures and increased public awareness of the issue. This balanced approach to tackling the issue of violence in the health sector has been echoed throughout the world (WMA 2008; ILO 2003; BMA 2003; ILO-ICN-WHO-PSI 2002).

The risk of being subjected to violence when working in the Israeli health care sector is one of the highest when compared to other work environments (McPhaul et al. 2004). Both the Israeli Medical Association (IMA) and the Israeli Ministry of Health are aware of this growing problem and have been trying to deal with it by introducing a range of reforms. This paper identifies the initiatives introduced in Israel and evaluates their effectiveness. The reforms introduced in Israel are three-fold and include: financial initiatives, legal actions and social projects.

Strategies and initiatives in Israel

The Ministry of Health set up a committee to investigate the issue of violence in the health sector and present strategies to cope with it. Following the committee's recommendations, in the year 2000 the Director General of the Ministry of Health presented a directive, recommending the implementation of: 1) an established reporting system; 2) protection by three on-duty guards in every public hospital; 3) training of staff to cope with potentially violent patients; 4) education of medical staff in communication skills; 5) greater cooperation with the police; and 6) the installation of technical measures for control, inspection and warning, including: CCTV's, emergency alarms and improved waiting areas. It was decided that hospitals must organize and prepare for this plan of action, which was to be completed by April 2000. Although these recommendations were adopted by the Ministry of Health, they failed to be implemented.

The IMA subsequently published a position paper noting the inaction of the Ministry as well as a lack of reference to violence in the ambulatory setting, where this phenomenon exists in increasing quantities.

Financial Initiatives

Violence in the Israeli health sector has continued to escalate over the years. In 2008, the Israeli Medical Association appealed to the Supreme Court to obligate the Ministry of Health to implement both an emergency plan and the permanent directives of the Director General's report. The Ministry of Health was criticized for not implementing its own plan. Immediately following this criticism, the Ministry of Health set a budget of 2 million NIS to reduce violence against physicians and Clalit Health Services, the largest health fund in Israel, budgeted NIS 2.5 million for the same purpose. Without designated funds, there is no way to implement plans and directives into concrete action and many ideas will remain on the drawing board.

Legal Measures

The IMA has proposed several bills in Parliament to deter patients from attacking medical staff. These bills were developed, in part, on the basis of a successful action plan implemented in England in 2000 to reduce violence against medical staff. In 2006, a bill to prevent violence against health care workers passed its first reading in Parliament, proposing that a violent offender would not be entitled to receive treatment in the institution where the incident occurred, for a minimum of 3 months, except in cases of medical emergency. Another bill increasing the punishment for those who attack medical personnel was accepted in its first draft and is now part of Israeli law. The bill states that offenders may receive up to 5 years imprisonment for attacks made on health care workers.

The IMA also proposed an amendment to the Patient's Rights Act which states that the physician has the right to refuse to treat previously violent patients, except in emergency situations. Eliminating legal barriers to withholding medical care is expected to reduce physicians' ethical dilemmas related to such a decision (Gross et al, 2008). The IMA also submitted a bill to promote the job of hospital security guards by making theirs a government endorsed profession, resulting in their receiving a bonus. Both bills are currently in their second reading in Parliament. In 2008, meetings were held between the IMA, the Minister of Health, and representatives of the Israeli police and the security division of the Ministry of Health. Following these meetings the Israeli Police established the following guidelines for dealing with violence in the health sector:
1) Implementation of an accelerated inquiry process in every case.
2) Determination that police officers will consider the release of detainees on condition that they are excluded from the hospital where the offense was committed, and that the hospital security officer will be informed of their release.
3) Agreement that closing cases of violence against a public servant on the grounds of lack of public interest is against Israeli police policy.
4) Adoption of a "zero tolerance" attitude.

In addition, the IMA met with the chief of police, chief of investigations and other senior officers of the National Police Headquarters who adopted many of the IMA's requests including: reinforcement of security, giving high priority to the presence of a patrol car after violent occurrences in hospitals, and the expansion of the powers of security officers in medical institutions.

The legal system also, indirectly, helped reduce some of the pressures that lead to violence when, in June 2008, the district court in Tel Aviv ruled that doctors are not allowed to include budgetary considerations in their medical decisions (Appeal No. 00199/07 Dr Zvi Raviv. Ministry of Health). It is hoped that this decision will restore the doctor's professional autonomy and minimize the tension between doctor and patient.

Social Projects

It has been suggested that zero tolerance is not always an effective response to violence in health care settings (Holmes, 2006). Therefore, on top of the legal and financial measures implemented, the IMA approached the problem of violence on several other fronts. The IMA manages an emergency hotline (24 hours a day, weekdays and Sundays) for doctors who have been victims of violence, providing immediate advice and assistance. The Association also contracts with a professional security company to accompany doctors who have been attacked and appear to be in further danger, and provide them with additional security and professional advice. The IMA has used the field of communication in an attempt to get its message across. In its own publication, "Zman Harefuah" (Medical Times), there is a regular call to doctors

to report any incidents of violence. The IMA also publishes frequent press releases in response to violent incidents, resulting in extensive press coverage. The IMA produces and distributes posters focusing on violence in hospitals in order to increase awareness of the problem. Finally, the IMA produced, in conjunction with a professional media company, a video clip on the topic of violence against physicians that was broadcast on Israeli cable television.

Informal communication is also used as a tool; doctors from hospitals where violent incidents have taken place have frequently held protest rallies following the event, and the president and high officials within the IMA and medical institutions participated in a protest in front of the Ministry of Health urging them to act more forcefully with regard to violence in the health sector.

The IMA works with the hospitals in an attempt to ensure an environment that will deter, if not eradicate, violence. For instance, the IMA partnered the pilot project "Hospitals without Violence" at Wolfson Hospital, which was slated to add emergency buttons, security cameras, magnometers and increased security personnel. However, due to the high projected costs (NIS 1,500,000 or approximately USD 395,000) the project did not get off the ground. The IMA did, however, succeed in helping to advance a pilot of mobile emergency buttons in the operating rooms of Sheba Medical Center.

Hospital directors were also requested to come up with a range of quick solutions that could be implemented almost immediately, including: allowing patients to be accompanied by one person at a time, installing a magnetometer at the entrance of every medical institution and placing security cameras in all operating rooms. While some of these requests have been implemented in many hospitals, others have been unable to do so because of financial restrictions.

Results

The extensive activities of the IMA and consistent pressure on the Ministry of Health have led to significant measures and considerable financial investment to reduce violence in the health sector. It is hard to say which, if any, of these activities and laws have had a direct effect on the number of incidences of violence in the health sector. Nevertheless, these measures do correlate with a reduction in both physical and verbal attacks on physicians in Israel and it is clear that since these actions began the number of violent attacks in the Israeli health sector has decreased. In the year 2003 there were 1250 physical attacks on physicians, while in 2008 this dropped to 902 and in 2009 it decreased further to 578 attacks. Until 2008, verbal attacks in the health sector in Israel were not recorded. However, it can be seen that these are also on the decline, with the number of verbal attacks in 2008 reported to be 2736 while in 2009 this was reduced to 2116.

Conclusion

These findings, together with previous research, suggest that in order to effectively tackle the issue of violence in the health sector a balanced approach, comprised of activity on several fronts, is needed. In addition, collaboration among various players, including government, national medical association, hospital and general health services and the police is more effective than the individual efforts of any one party. However, there is still a long way to go, as violent acts in the Israeli health service are still taking place. In the legal arena, the IMA continues to promote the bills being discussed in the parliament, which aim to ban attackers from the hospitals where the violence occurred and provide additional powers to security guards in hospitals. Further cooperation between governmental bodies, police and non-governmental associations such as the IMA is required to continue building successful policies and frameworks. Within the hospital and health care practices, more training is required for staff. As Landau (2004) reported, 80% of ER staff had not participated in any training in the area of dealing with violent acts. In the public domain, the IMA will continue to encourage staff to report any violent events and will publicize efforts through internal mailings and through the media.

All in all, there is no escape from recognition that although we want our work to eradicate violence against physicians, only a state-level comprehensive plan may lead to a significant reduction of the phenomenon – and for that a dedicated budget is required.

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Correspondence

Mrs Malke Borow
Israeli Medical Association
35 Jabotinsky St, P.O.B 3566
52136
Ramat Gan
Israel
+972 361 004 44
malkeb@ima.org.il

A move for change - No move violence

Paper

Barbara Rabin, Boaz Yaari, Yosi Noga, Gadi Damti, Rachel Ziv, Zvi Klein, Yochi Ben Nun, Marina Leonenko, Mira Maram-Edri
Meir medical Center, Kfar Saba, Israel

Abstract

Background

The phenomenon of violence in the workplace has a high prevalence worldwide and even more so within the health system. The professional literature describes many cases of heath professionals that were the victims of violent behavior from patients or their families. Notwithstanding great efforts in the past, on behalf of the health team at the Meir Medical Center (The Clalit Health Services Group) Israel, violent incidents over the years have not decreased. On this basis the Violence Prevention Committee in the facility decided to carry out a consistent program to detect the factors that lead to violence in the hospital setting, and its prevention.

Aim

To reduce violent incidents against the treatment team that takes place in the medical center.

Goals

1. To formulate a systematic policy about the violent incidents.
2. To map out the places and the reasons that contributes towards violent behavior.
3. To reinforce knowledge and attitudes for the team and the provision of tools to prevent and cope with violent behavior/
4. To provide support to the treatment team, following violent incidents.

Working process and methodology

1. A strategic decision of the hospital management together with the Violence Prevention Committee to target this as a major issue to be dealt with.
2. Initiating surveys for the detection of possible areas for violent behavior.
3. Initiating information surveys in the hospital for workers from all sectors
4. Analysis of the surveys from the sectors and decision making regarding intervention
5. Sectorial intervention including: Structural changes in places susceptible to violence, engaging extra 'key persons', defining follow up for violent behavior, defining the process of work about the effectiveness of the violent acts and afterwards, provision of workshops to the wards that exhibited high cases of violence.

Results

1. Structural changes were planned and implemented in those places where there were high incidents of violence. Security buttons were strategically places in these areas.
2. The survey revealed (311 staff participated in the study) that knowledge of the hospital staff related to behavior at the time of violence was low (over 40% of the participants reported that they did not know what to do at the time of a violent incident), few of the subjects knew with certainty to whom to turn to for help (15.7%). Also it was found that the teams that were exposed to violence, did not receive enough feedback from management with regard to how effectively(or not) they performed(44.3%)The results of the survey and the intervention program was passed on to the workers in the hospital.
3. A policy for the organization was formulated on the subject of violence against hospital teams.
4. The processes of prevention and coping with incidents of violence were defined and transmitted to all the workers.
5. Workshops and other tools to improve team coping with this behavior, was instituted.
6. Follow up of violent incidents in the hospital was monitored and individual treatment was provided to the medical team exposed to physical violence.

7. The population who had a tendency to be lenient with acts of violence were detected and given appropriate treatment.
8. In 2009 violent incidents were significantly decreased
9. Further results will be presented at the conference.

Correspondence

Mrs Barbara Rabin
Meir medical center
Tshernichovsky
44281
Kfar Saba
Israel
+97 9 747 25 55
Barbarara@clalit.org.il

Workplace bullying and lateral violence: A conceptual model for violence awareness and reduction

Paper

Mary Alice Melwak, Mara Collins, Graham Fewtrell
UCLA Healthcare, Los Angeles, USA

Abstract

Bullying and lateral violence continue the aggressive assault on healthcare workers, the work environment, and ultimately patient safety. Toxic workplace behaviors such as bullying and lateral violence adversely affect multiple fundamental facets of unit culture and markers of quality patient care. Workplace bullying and lateral violence are complex, multilayered phenomena that contribute to moral distress, dysfunctional and harmful work environments, and adverse patient outcomes.

The current and increasing complexity of healthcare systems presents escalating challenges to organizational leaders to address the origins and the effects of toxic workplace cultures. Understanding organizational and theoretical complexities of bullying and lateral violence is paramount to implementing change initiatives that reduce both overt and covert toxic behaviors and affect the ethical climate of healthcare units. Leaders must reverse the cycle of toxic work environments through deliberate interventions that increase the level of communication, collaboration, and respect among their members.

Leadership and staff expertise, values, experience, expectations, and positive behaviors must be grounded in a practice environment infused with both awareness and a template for action to assess violence levels and adapt quickly to bullying patterns that affect clinical excellence, care, cost-effectiveness, critical thinking, empowerment of staff, and professional growth.

The purpose of this review is to describe a conceptual model for bullying and lateral violence that addresses negative behavior etiologies as well as treatment measures and strategies to overcome barriers to effect culture change in hospitals. Significant contemporary perspectives stress the multiple levels of determinants of organizational culture change. We utilize key types of theory concepts such as change theory, situational awareness, social influence theory, and transformational leadership as the foundation for leadership interventions. Moral distress, ethical climate and levels of organizational distress are discussed with the ecological model serving as the framework for multiple level pathways for leadership initiatives.

The model addresses the central issue of organizational culture change and organizational transformation and the relationship to optimizing a productive and healthy work environment as a reduction strategy to diminish the detrimental effects of bullying and lateral violence. A conceptual foundation for understanding bullying, lateral violence is delineated with a synthesis of the evidence regarding patterns and effects of theory regarding sustaining culture change to effectively reduce levels of bullying and lateral violence.

In addition, the conceptualization illustrates the viability, utility, and challenges of using theory-based interventions to initiate and evaluate effects on bullying and lateral violence in hospitals. This review concludes by identifying cross cutting themes and important future directions for bridging the gap between theories, practice, and research. Response patterns that are evidence-based are discussed along with competencies for positive culture change for staff and leadership.

A cultural change schema for bullying and lateral violence management process is embedded within the model for unit and organizational level leadership. The review concludes with suggested strategic management strategies and associated risks inherent establish a change-oriented organization with the culture and capacity for safe and healthy work environments.

Correspondence

Mrs Mary Alice Melwak
UCLA Healthcare
10833 LeConte Avenue
90095
Los Angeles
USA
+1 310 825 5004
mmelwak@mednet.ucla.edu

Bridging the gap: Dealing with both domestic violence and violence in the health sector

Workshop

Marion Steffens, Ulrike Janz
GESINE-Netzwerk Gesundheit.EN, Schwelm, Germany

Keywords: Domestic violence, health consequences and the health sector

In the early seventies of the last century, international women's liberation movement began to set a focus on violence against women and brought this topic to public attention. In the decades since then shelters for battered women opened their doors on every continent. Counselling services were established, programs for perpetrators have been developed, and specific laws have been adopted. Different professions like the police, lawyers, courts, social workers started to reflect on their professional role in combating what is now called domestic violence (DV).

Introduction

During the last years also the health sector has become more aware of the relevance of domestic violence. In 2002 the WHO stated that violence – especially DV – is one of the major health-risks for women and children (Krug et.al.2002) worldwide. Domestic violence bears many faces and has substantial and most notably long-term consequences for the victims´ health (cf. Figure 1: The Power and Control Wheel – forms of DV, developed by Domestic Abuse Intervention Project, Duluth 1983, this version from jnetsworld. blogspot.com and fig. 2: Health Outcome of DV, from Change 1999).

Figure 1: The Power and Control Wheel

Isolation
Controlling what she does, who she sees and talks to, where she goes.

Emotional Abuse
Putting her down, making her feel bad, name calling, mind games - making her think she's crazy.

Intimidation
Causing fear using facial expressions, tone of voice, gestures, smashing things, destroying her property.

Economic Abuse
Stop her from getting a job, taking her money, making her ask for money.

Power and Control

Using Male Privilege
Treating her like a servant, making all the big decisions, acting like the master of the castle.

Sexual Abuse
Making her do sexual things against her will, attacking the sexual parts of her body.

Threats
Threatening to take children, commit suicide or homicide, report her to welfare, hurt pets.

Using Children
Making her feel guilty about the children, sending messages through the children, using visitations to harass her.

Figure 2: Health Consequences of domestic violence

Figure 3. Health Outcomes of Violence Against Women
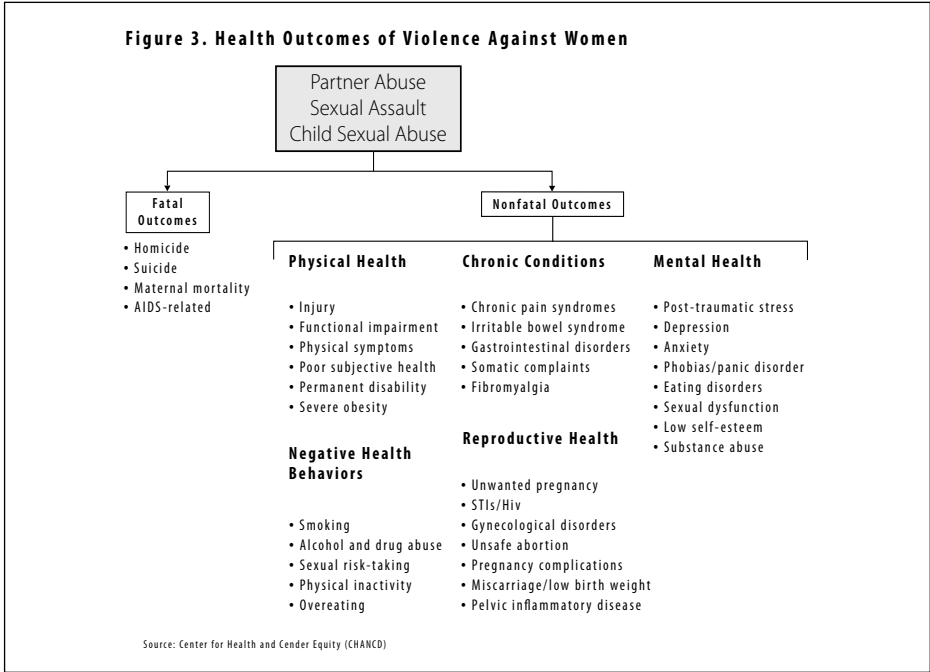
In a German study it has been assessed that already singular acts of violence increase the amount of resulting physical and emotional symptoms even if no injuries occur. The following patterns of violence have been found to be especially causing harm to health:
• Emotional Violence of higher intensity, but no physical violence
• Physical Assaults of lower to higher intensity plus more severe emotional violence
• Severe physical and/or sexual violence in combination with emotional violence of higher intensity (c.f. Figure 3, data from the German study by Müller/Schröttle 2004, graphics by GESINE)

Figure 3: Patterns of violence – health outcomes
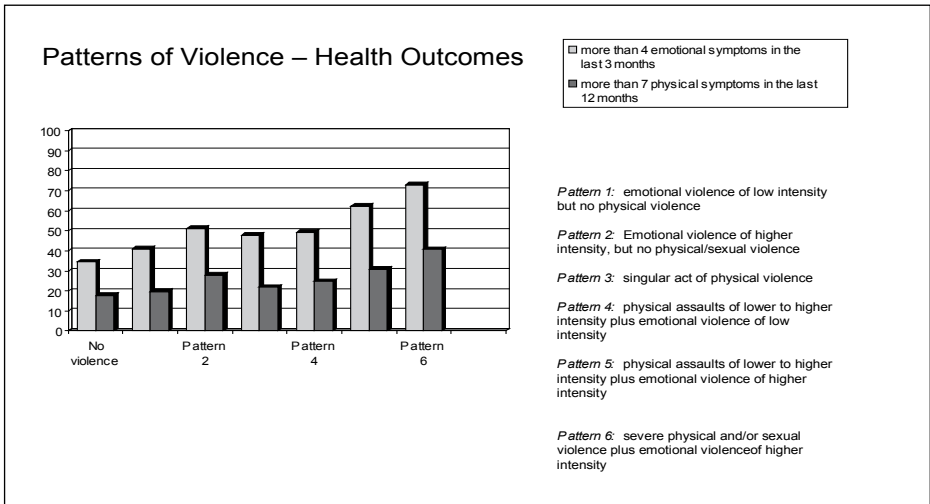
In his longitudinal ACE-study linking adverse childhood experiences to a range of health outcomes Felitti et al. (2002) proved that people witnessing DV during their childhood experience long term health, social and economical consequences even in adulthood. From many other studies we have learned in the meantime, that health consequences are the worse, the less support the person as child or adult has found in processing suffered violence and in forming confident relationships. Witnessing DV leads to different "Risk-paths" in adulthood for boys and girls:

• girls have a double risk to become a victim of violence in a partnership as adult
• boys have an 8 times higher risk to use violence against a (female) partner.

The consequences of DV are therefore relevant in the health sector for different reasons:

1. Violence has significant health consequences. Due to the multiple and complex health disorders it requires an appropriate consideration in the treatment context. Violence is often not recognised as a cause of injuries and symptoms. According to a Canadian study, merely in one out of 25 cases violence was identified as the cause of the problem (Day 1995). A study conducted in Berlin shows that GPs detect domestic violence only in one out of ten cases (Mark 2000). Intimate Partner Violence is often unrecognized by health care professionals. This lack can result in inappropriate health care responses like false diagnosis, medicalisation or inadequate care. And this may result in both an extended and intensified health strain on victims of violence leading too significant consequential costs in the health system.
2. If men or women have suffered or witnessed DV as a child, this has an impact on their attitudes as a patient – not only in the case of PTSD. Violence-induced behaviour can appear both in the inpatient care and in home care and also in the context of outpatient medical treatment. If the patients behaviour is not linked to suffered violence, this can result in not safe situations (e.g. Nursing in an old people's home: The resistance of a female inhabitant to have her panties pulled down in the bathroom; or during an gynaecological examination: The feelings of a women who has suffered rape who has then to endure an intra-vaginal examination without warning).
3. To have suffered DV has an impact on the attitudes of health care professionals. Some may have few resources to defend themselves against violent patients and to deal in an adequate way with dangerous situations. Some may be more aggressive towards dependent patients. And others have less (or more!) problems to talk to patients about their experiences with DV.
4. Health institutions participate in the taboo of the DV issue by claiming it to be a strictly social problem, e.g. in the context of the debate about routine enquiry for DV when the assumed damage to the mutual trust between doctor and patient is scored higher than the positive results of an early detection of violence.

Despite all these good reasons for taking DV in the health sector really serious, reality in Europe shows a different picture. While in the United States DV and its health consequences have been issues of intense research since the seventies, the corresponding results in Europe are still relatively sparse. Accordingly the development and even more notably the implementation of appropriate, practical intervention programs in the health sector proceeds quite hesitantly. There are promising programs in different European countries (e.g. UK, Switzerland, Austria, Spain, Germany, the Netherlands).

The development of intervention programs that are not restricted to a single institution in the health sector (e.g. hospitals) and further more to single units (e.g. emergency departments) is just beginning. GESINE has by now developed programs and tools for a range of health professions and for physicians in private practice (different specialities) and is recently implementing a program for all units of one hospital. Within a national pilot project in Germany tools and trainings are evaluated concerning their practical relevance, manageability and acceptance (2008 – 2010, cf. www.migg-frauen.de).

The Network GESINE

GESINE was established in 2004 to improve the health situation of victims of DV and their children effectively and sustainably. Therefore we had to:

• improve the awareness of DV within the different health care services,
• improve knowledge, skills, attitudes and referral competences of health care professionals to adequately react on DV,
• develop tools to give practical support to health care professionals,
• support the development of special services within health care institutions,
• implement cooperation procedures for health care and DV support services, and
• create procedures to ensure lasting effects.

We identified the specific role of all social and health care providers who would get in contact with DV survivors. We identified the possible benefit network partners should have by getting involved. GESINEs work is based on national and international research.

We already knew that to gain sustainable effects it would not be enough just to provide singular training or to send unrequested information or recommendation to hospitals and private practices. Our multi-professional task force had to discuss beyond training curricula and the main messages of a sensitization campaign. It was essential to think about sustainability and collaboration.

GESINE has a 3 level approach to gain sustainability and collaboration:

1. Level: The health care professional and the institution she or he´s working in
• Providing certified training by following a modular training concept that is tightly tailored for every health and social care profession.
• Implementing the GESINE – Intervention program in hospitals, clinics, private practices, counselling services
• Providing coaching to help institutionalise the intervention concept and protocols
• Providing case-advocacy

2. Level: regional approach throughout the municipality
• Establishing and coordinating a multi-professional healthcare related network
• organization of annual interdisciplinary conferences
• Providing a database, showing all health institutions already trained on DV
• Ongoing PR

3. Level: Patients as target group
• Providing health education and patient information handouts
• Establishing a pilot function to give patients support through health and social care services
• Implementing a feedback system for ongoing quality development like questionnaires, and measures for impact.

GESINE Intervention Program

To demonstrate the derivation of the German acronym GESINE the German description is presented with an English translation.

German	English translation
Gewalt erkennen: Achten Sie auf Red flags	Perceive violence – be aware of Red Flags
Ermöglichen Sie eine vertrauliche Gesprächsatmosphäre	Facilitate an atmosphere for a confidential conversation
Sprechen Sie das Thema Gewalt mit sensiblen, direkten Fragen an	Address the violence issue with direct, sensitive questions
Informieren Sie über Unterstützungsangebote und vermitteln Sie die pro-aktive Hilfe	Inform about support-services and facilitate „pro-active" help
Notieren Sie den Bericht der Patientin und dokumentieren Sie etwaige Verletzungen und Beschwerden	Take notes of the patients reports and document injuries and complaints
Erfragen Sie den Bedarf nach Schutz und Sicherheit.	Request the patients need for protection and safety

Connections: Violence in the health sector and Domestic Violence

Independently of the first positive developments on the issue of DV and healthcare the issue of violence in the health sector has gained some momentum during the last years.

The issue is multilayered: Violence takes place in different places. Violence is practised by caregivers against patients; by patients against caregivers or against other patients; by superiors against staff; among colleagues against each other. Violence can be physical, emotional, economical or sexual, it might be a kind of neglect, it can be wielded in the "heat of emotion" or as a steady strategy. Violence can be fatal. DV and Violence in the Health Sector (ViHS) share a lot of similarities and are furthermore correlative. Some examples:
• A female patient is just currently separating from her violent partner
• A patient has experienced violence in prison
• A nurse on a surgical unit experiences sexual abuse by a senior physician
• A gay male nurse is mobbed by co-workers
• A female doctor suffers violence by a partner
• A child-patient has recently witnessed her/his fathers violence against his/her mother
• A male therapist rapes a client
• A nurse is tying up a patient
• A male nurse refuses to help a patient needing the lavaratory

Taking in account these (and many more) connections between DV and ViHS it´s all the more astounding that the engagement with DV on one side and ViHS on the other side stays up to now in Europe still relatively unconnected. With reference to Germany we can indeed say that a debate on the connection between DV and violence in the health sector barely exists.

Why does it make sense to connect the issues of DV and ViHS?

Considering a DV lifetime-prevalence of 25% for all women, it is obvious that many female patients (e.g. in a hospital) have either suffered violence by a partner at some point(s) in their life or just experience it right now. The same holds true for women and men working in the health sector. Many of them have experiences with DV – as a victim or as a perpetrator. So what does it mean for the health sector, when employees go from a non safe home to a non safe workplace?

One example

Anna lives with a violent male partner. As a nurse in a nursing-home she worked with a group of demented patients. There she repeatedly suffered sexual assaults by a patient. After the first assault she told a colleague. The colleague offered some advice how to deal with that patient and suggested to Anna, that the assault was her own fault because of acting unprofessional. At home Anna talked to her partner about feeling harassed by a patient. Her partner became aggressive and blamed her for what happened because of her "provocative behaviour". Some time later Anna asked for a job transfer without giving any reasons. Her replacement likewise suffered sexual assaults by the same patient – but she talked about it for the first time in an anti-violence training program.

Also patients who are victims of DV and come to a hospital, a place that is supposed to help them regain health and well-being, can not really feel safe there. E.g. an old woman who has suffered DV for more than forty years is now a very frail, dependent patient. On her first morning in hospital a very nervous, strained nurse (male or female) is treating her very harshly while bathing.

What to do: First steps

Only very few health institutions already have implemented a program for handling traumatized or DV victimized patients and very few institutions offer ongoing training on the DV issue. Networking with support services to facilitate a target-oriented referral is, e.g. in germany, not yet institutionalized. Necessary modules for such an implementation can be shown e.g. by the Kaiser Permanente Program against DV in California, USA (cf. Figure 4, more: http://xnet.kp.org/domesticviolence/about/index.html).

Figure 4: Domestic violence prevention systems model implementation

Domestic Violence Prevention Systems Model Implementation

Screening and Referral

On-site DV Services

Leadership and Oversight

Supportive Environment

Community Linkages
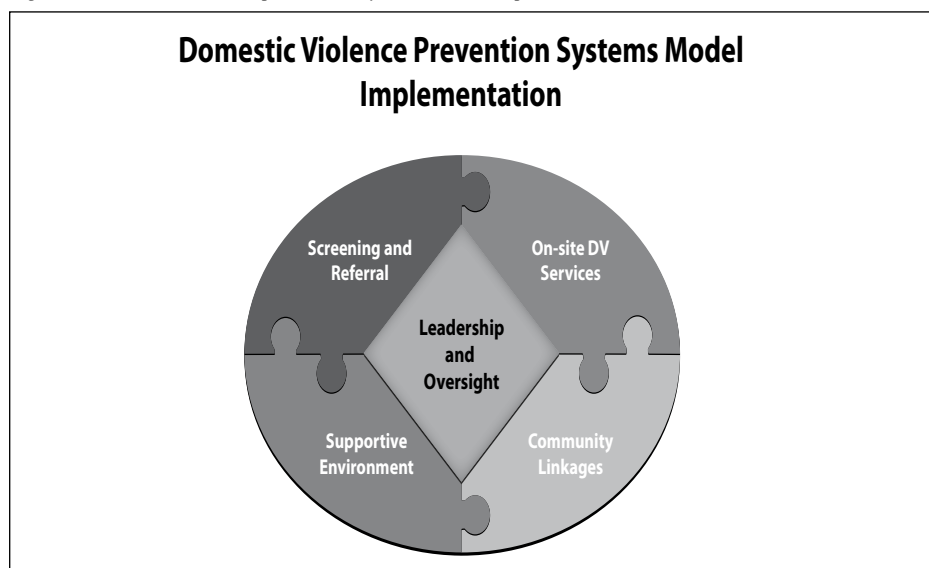
Violent behaviour by male and female staff in the health sector is also not sufficiently debated in health institutions. Training-modules to handle one´s own aggression and excessive demand plus to learn to reflect on one´s own violent behaviour should be obligatory in training and advanced training. Further more this would be an important module of institutionalized coaching for health care professionals.
The discussion of violence in the health sector demands a broad view on the connections between different kinds of interpersonal violence – a cross sectional approach will be most promising here!

Everyone can make a next step by taking part in the discussion of violence - that means to be sensitive to the relevance of (domestic) Violence in our daily work (and live): Everybody can be a changemaker.

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Correspondence

Mrs Marion Steffens
GESINE-Netzwerk Gesundheit.EN
Markgrafenstr. 6
D58332
Schwelm
Germany
+49 233 647 591 52
steffens@gesine-net.info
www.gesine-net.info

Building a safe and risk aware organisation: research on willingness to report unintended events

Paper

Marieke Troost, Linda van den Brink

Keywords: Dimence, risk management, safety, risk awareness, incident management, reporting, unintended events, incident, risk

In mental health care, client care is never fully without risk. The client, for example, finds himself in an unfamiliar environment and must depend for the most part on the information and safety provided by others. Looking after clients is also not without risk for the employee: they can be faced with aggression and shocking events, such as attempted suicide. To diminish that risk it is necessary to pay explicit attention to risky situations and what can be learned from them. To achieve this culture, change is needed.

This programme is the key element in changing incident management in risk management. The Risk Management Programme contains projects that cover essential preconditions as well as projects regarding the actual care. The Risk Management Programme is essential in achieving the high quality and safety of care Dimence pursues. It ensures growing professionalism and the individual's being able to depend on colleagues, which enhances both the actual safety and safety feelings. These are all prerequisites for good care provided by the employee, of which in the end the client and the employee will benefit.

In the Risk Management Programme we are all working towards the same goal: safety and risk awareness. Elements that are needed to achieve this goal are (a.o.):
- Increasing employee awareness of the risks and willingness to change;
- Enabling employees to further develop the skills to prevent or minimise coercion by applying 'good practice' alternatives.
- Enabling employees to develop their skills through a training program in risk management, which includes a training by (former) clients in client-employee interaction and a training by safety consultants in handling aggression;
- Encouraging employees to report and learn from (near) incidents and risks

With regards the latter, Dimence has conducted a study into the willingness of employees to report unintended events. Although a number of incident reports are submitted within the organisation, we do not have sufficient information to ascertain if this is the complete picture or just the tip of the iceberg. Dimence believes that reports provide an important source of information with which to improve workplace safety conditions. The fact is, by analysing the causes of incidents or near incidents and by implementing comprehensive improvement measures, we can prevent risky situations occurring in the future. Furthermore, discussing the number of incidents or near incidents with one another will also lead to improved awareness of the risks involved in working in mental health care. As far as we know is Dimence the first organisation in the Netherlands that has conducted a study.

The study focuses on the following question: Which factors influence the decision-making process of whether or not to report unintended events among employees participating in Dimence's primary process? Sub-questions formulated in response to this main question are: To what extent do employees experience unintended events in the workplace and how do they deal with them? And what are the reasons behind an employee from the Dimence primary process deciding to report an incident or not?

The results show a substantial gap between the number of unintended events that have taken place and the number that have been reported. Only one of the sixteen unintended events was reported. A variety of reasons were given. One of the most frequently cited was that it is not always clear to employees which unintended events should be reported. The study also revealed that the ability to think in terms of safety played an important role.
The challenge is to translate research results into solutions and procedures that effectively contribute to the goal, increasing safety. We have made a head start by implementing the recommendations of the study. Two main objectives are the introduction of a digital incident reporting system for employees and the

creation of local safety committees. These are two essential preconditions, leading to success. However, it remains an ongoing process.

Correspondence

Dimence
Marieke Troost
Linda van den Brink ()
P.O. Box 5003
7400 GC Deventer
The Netherlands
l.vandenbrink@dimence.nl

Health providers' response post-screening for intimate partner violence

Poster

Martha L. Coulter, Farah Ahmad, Susan M. Hadley, Melissa Cristal, Mercado Crespo, Carla VandeWeerd
The Harrell Center for the Study of Family Violence, University of South Florida, Tampa, USA

Abstract

Background

Each year, 4.8 million women in the United States (US) suffer from intimate partner violence (IPV), making it likely to be encountered by physicians, nurses and other health providers in the clinical setting. Nonetheless, the needs of IPV victims are many times unmet because of their reluctance to seek or receive services or because the health provider was not able to identify IPV as the underlying cause of the patient's signs, symptoms or conditions. Physicians and other health providers have a unique opportunity to connect and intervene with IPV victims, as the health care setting could be the only access point IPV victims may have to seek, be offered and receive help. Although a significant number of health professional organizations (e.g., American Medical Association) encourage and support health provider's screening for IPV, there is limited evidence available on the effectiveness of screening, interventions to prevent IPV, and improved health outcomes for those involved. Likewise, evidence is also scarce on the steps taken by health providers after a patient is screened for and identified as an IPV victim.

Purpose and objectives

The purpose of this study was to identify the post-IPV screening steps taken by health providers, medical office, clinic and hospital personnel, and examine their opinion(s) and knowledge on the services available for IPV victims at healthcare settings. Specifically, this study:
• Described IPV screening practices among a convenience sample of health providers.
• Assessed the relationship between IPV policies, procedures and services offered by the workplace, and health providers' response to IPV.
• Compared health providers' expressed need for resources, and their reported IPV training received.

Methods

A convenience sample of health providers working at health-related settings – specifically, members of the American Public Health Association's (APHA) Family Violence Prevention Forum (FVPF) – were invited to participate on a cross-sectional quantitative Internet-based survey. FVPF members include approximately 1000 physicians, nurses, social workers, psychologists, public health practitioners, physical/occupational therapists, midwives, dentists, and other professionals from across the United States and abroad, who are invested in family violence research, prevention and intervention. Individual e-mail invitations were sent via CheckBox – an Internet-based survey system, provided by and housed at a secure server, at the University of South Florida (USA) – to FVPF members with valid e-mail addresses. No identifying information was collected.

Data analysis and results

Findings from this study will be present discussed General demographic characteristics of the study sample will be described, as well as participants' responses across each of the study's main research areas: 1) IPV-victims identification and providers response protocols for healthcare settings; 2) IPV training received by health providers; 3) health providers' knowledge, attitudes, beliefs and behaviors on IPV, the availability of information and related resources; 4) knowledge of victim services available in the workplace and community and 5) workplace policies and procedures post IPV-screening. Associations between workplace procedures and policies to respond to IPV-victims, and the availability of IPV services at the workplace, as well as the respondents' reported IPV-screening practices will be explored.

Correspondence

Mrs Martha L. Coulter MSW DrPH
The Harrell Center for the Study of Family Violence, University of South Florida
13201 Bruce B. Downs Blvd. MDC 56
33612-3807
Tampa, FL
USA
+1 813 974 7829
mcoulter@health.usf.edu

Claudia's Nightmare: A short film dealing with psychological violence in the Health Sector

Workshop

Dolores Crespo, Covadonga Caso, Vicente Arias, Macarena Gálvez, José Carlos Mingote, Pablo del Pino, Luisa Rodriguez, Angeles Sanchez, Luis Vega, Rosa Esteban, Carmen Moyano & Javier Rodriguez
Safety and Health sector Public Hospital Clinico San Carlos, Madrid, Spain

Background

The occupational violence in the Health Sector implies a threat which damages the safety, health, efficiency, productivity and decent job. It is necessary to issue a statement regarding non-tolerance of occupational harassment in which every health care professional ranks are involved. This statement must also include a complaint system as well as, the willingness to promote information, education and formation in terms of unacceptable behavior. The justification of the project relies on the directive published by the International Labour Organization in 2003 which drew up several recommendations regarding the Workplace Violence in the Health Sector. These recommendations promoted the preventive approach, based on the system of occupational safety and health.

For more than ten years, the Spanish labor system has been aware of the problems caused by stalking. The health sector has also been connected to this awareness; therefore, several studies have been developed in professional colleges, labor unions, scientific societies, etc. in order to board the dimension of the problem. Along 2008-2009, the Mental Health Office in Madrid in collaboration with occupational safety and health areas from public hospitals, gave priority to this problem, by establishing the study "Prevention of the Internal Violence in Health Sector in Madrid" which was granted by the Ministry of Health and Social Policies included in the Funding Program for Cohesion between Spanish Regions.

Study aim

The principal study objective is the prevention of occupational harassment in the Health Sector in Madrid by the definition of the preventive policies. It is necessary to issue a document mentioning unacceptable behaviors in the health sector. It is also necessary to promote information-training strategies addressed to employees as well as to reach a procedure that faces the conflict in collaboration with a mediator. The secondary objective is addressed to improve the medical attention to patients, by controlling the repercussions derived from internal violence in the health sector.

Method

The methodology has lead by the Mental Health Office (Madrid) granted by Spanish Ministry of Health and Social Policies. It has been created a researcher group represented by: Psychiatrists in charge of Mental Health Office, Specialists on Occupational Medicine, Head of Occupational Safety and Health Areas from Public Hospitals, three psychiatrists and one psychologist from the Program of Integral Attention to the Healthcare Workers and Physicians. This researcher group has also hired three scholars. The group counts on the enough experience in assessment and management of violence after the participation during five years in Health Care of Physicians Program at College of Physicians in collaboration with Program of Integral Attention to the Healthcare Workers and Physicians.

Among the methodological activities, it can be mentioned the following: bibliographic research and contact to consultants in Madrid, researcher group's weekly meetings and contact to experts for training the group, meetings with ten consultants-experts on the violence topic, contact to the short-film production company (Tamagaz Films), attendance the Violence Risk Courses, attendance the Mindfullness-Based Stress Reduction. Presentation of the Project exhibited to the Public Hospitals in Madrid, a round table meeting attended by Nurse official College, Official College of Physicians and Social Work Official College, elaboration of the document which will be provide in the Pen Drive format at final presentation of the project in Lain Entralgo Official Agency for to health workers training.

The researcher group has managed to achieve the establishment of weekly meetings in collaboration with experts on managing workplace violence as well as the acquisition of the computer equipment, compilation and revision of bibliographic references in terms of workplace violence in the health sector, revision of the initiatives, protocols and other documents from Spanish and worldwide organizations and the assignment of several experts dealing with ethics, stress, law and mediation, in order to optimize the group's occupational training.

Results and discussion

Among the results reached, it can be highlighted meetings in collaboration with experts by obtaining the active participation of the members of the group (moral harassment, audiovisual techniques, occupational safety and health for healthcare workers, mediation and conflicts negotiation, psychosocial stress disorders unit and risk groups. We have also managed to create a database of bibliographic references regarding violence as general term, and the occupational violence through institutional protocols. It has been developed an informative material for training which will be distributed among the healthcare employees in 400 pen drive format. The members of the researcher group have also attended the Violence Risk Training Workshops in Edinburgh concerning the tool Risk Assessment and Management of Stalking Behavior held in March 2010.

Among other results it can be mentioned the elaboration of an audiovisual piece (short film) which performs a fictional case of internal violence in health sector. This short film is intended to debate different unacceptable attitudes as well as the victimization carried by stalking. Finally, the establishment of two working groups addressed to develop different tasks. The working group 1 will be involved on the elaboration of a Behavioral Conduct Code and the working group 2 will be elaborating of a Preventive Protocol for Conflicts Intervention.

The conclusions pictured deal with the necessity to create a key measure to aware the consequences of occupational violence in the Health Sector. This could be a preventative measure addressed to report and train healthcare workers in order to avoid the violence in a horizontal and vertical direction. The experience derived from the activity of the Public Hospitals involved in this project, may be applied to other Health Institutions (in Spain or abroad).

In this extent, this short film, about 30 minutes long, represents a fictitious case of psychological violence between doctors in the Health Sector based on real data. The representation is an original initiative to tackle the problem of violence. The audiovisual piece of occupational violent behavior helps to understand to some extent, the consequences caused by it.

This short film pictures the story of a female doctor who is involved in psychological abuse situation at work. The harasser is her superior, other doctor staff, head of the department. The story also shows the consequences of a stalking situation at different levels such as personal, professional and institutional. It has been set in a theatre and the whole theatrical space represents the biographic dimension of the doctor. The different parts of the theatre are definitely all the biographic representation of what happens when the occupational stalking takes place.

The different parts have been developed as a metaphor of a hand. The victim's hand represents different dimensions in relation to her fingers. These dimensions are biological, psychological, biographic, interpersonal, and moral-ethic aspects. Regarding these aspects, the victim's hand includes the five dimensions that are affected as soon as the harassment takes place. The action is developed along all the different parts of the theatre. In each area it has been represented different dimensions and contexts in order to make a plural view of the effect of Occupational and Psychological Violence in the Health Sector.

The stage has been set to represent the occupational atmosphere; therefore, the labor relationship between the harasser and the victim has been performed at this part of the theatre. Here, the short film focuses on the institutional responsibility facing workplace violence. Proscenium arch represents the victim's biological component, in terms of the indirect physical damage caused by the conflict. Here, the audience can observe the physical consequences derived from stalking process.

The interpersonal relationships are performance in the stall, in which the different characters are seated depending on the relation established with the victim. Therefore, the different characters can interact simultaneously, as all of them can observe the victim from the different places on the stall. In terms of ethics and moral dimension, it has been represented through the corridor of the theatre. In some extent, the victim feels the peaceful outside throughout the window, whereas the inside, leads the audience to feel a

claustrophobic atmosphere, as consequence of the events developed on the stage. In the projection room, the victim develops the psychological dimension. This is the space committed to the conversations with the Psychiatrist character who provides the corresponding recommendations and therapy.

The short film is focused on the visual effect, by reducing the use of dialogues, to offer debate and personal interpretations. As a final point, the short film ends in a bittersweet way. The victim finally manages to go outside the theatre overcoming the problem of violence and its consequences. However, on the other hand, the harasser is still seated on the scenery waiting for the next victim. This audiovisual piece also includes an introduction and conclusion that acts as enlightening material. The introduction regards the technical and methodological procedure of the filming, outstanding scenes to pay attention to, as well as a reference to some controversial characters such as the psychiatric character, head of service medical unit, lack of family relationships and actions taken by occupational hazards departments. The conclusion bears the belated detection of stalking processes. It also deals with the absence of universal protocols confronting internal violence, lack of current preventive measures (mediation programmes), lack of an active participation of the labour union, lawyers, judges, healthcare managers, etc. The conclusion also mentions the necessity to assess the risk factors, the management of actions addressed both to harassers and victims, the prevention of a possible victim's relapse, the consideration of stalking as an occupational mental disease and finally, it mentions the possible strategies to provide training to healthcare workers regarding the non-tolerance to violent behaviors.

Conclusion

In conclusion, the short film offers an encouraging ending in which the victim solves the controversies while the Institutional Representation still holds the problem of Violence in the Health Sector. This audiovisual piece allows the audience to obtain different perceptions of what a stalking process means for the victim, and its consequences. It also helps to create debate among the audience at the same time that gives a space open to suggestions.

Acknowledgements

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Correspondence

Mrs Covadonga Caso Pita
Head of Occupationa
Safety and Health Sector Public Hospital Clinico San Carlos
Avenida Santuario de Valverde 75-G
28049
Madrid
Spain
+34 917508576
mcaso.hcsc@salud.madrid.org

Protocol of the prevention of the internal violence in the health sector in Madrid

Poster

Covadonga Caso, Dolores Crespo, Vicente Arias, Macarena Gálvez, Jose Carlos Mingote, Pablo del Pino, Luisa Rodriguez, Angeles Sanchez, Luis Vega, Rosa Esteban, Carmen Moyano & , Javier Rodriguez
General Public Hospital Mental Health Madrid, Madrid, Spain

Abstract

Justification of the project

In 2003, the ILO (International Labour Organization) drew up several recommendations regarding the violence in working places related to Health Sector. These Recommendations promoted the preventive approach, based on the system of occupational safety and health. The occupational violence in the Health Sector implies a threat to develop safety, health, efficiency, productivity and decent job. It is necessary to issue a statement regarding non-tolerance of occupational harassment in which all the professional ranks of Health Sector are involved. This statement must also include a complaint system as well as, the willingness to promote information, education and formation in this area.

Methodology

The Hospitals of Ministry of Health in Madrid has designated an investigatory group represented by: Psychiatrist in charge of Mental Health, four head of department in Occupational Safety and Health Areas from Public Hospitals in Madrid, three psychiatrists and one psychologist from the UVOPSE (Assessment Unit of Health Care of Physicians) in Madrid. The group of investigation has also hired three scholars (two psychologists and one administrative). The group counts on the enough experience in assessment and management of violence after the participation during five years in Health Care of Physicians Programme College of Physicians (Madrid) and the UVOPSE.

Achievements

- Establishment of weekly meetings in collaboration with experts.
- Acquisition of the computer equipment.
- Compilation and revision of bibliographic references.
- Revision of the initiatives, protocols and other documents from Spanish and Worldwide Organizations.
- Assignment of list of experts dealing with moral, stress, law, mediation, to optimize the group's formation.

Results

- Meetings in collaboration with experts in the subject of Violence involving the active participation of the members of the group (moral harassment, audiovisual techniques, occupational safety and health, mediation and conflicts negotiation, psychosocial stress disorders unit and risk groups.
- Database of bibliographic references regarding violence as general term, and the occupational violence through institutional protocols.
- The elaboration of information-formation material by distributing 400 pen drive among the employees from the Health Sector.
- The members of the investigation group have attended the Violence Risk Training Workshops in Edinburgh concerning the tool SAM (Risk Assessment and Management of Stalking Behavior).
- The elaboration of an audiovisual piece (short film) regarding the conflict of violence in Health Sector in order to make a representation of a fictional situation.

Conclusion

A key measure to the awareness of the consequences of occupational Violence in the Health Sector is the information-formation strategies for the health employees in order to prevent the violence in a horizontal and vertical direction. The experience derived from the activity of the Public Hospitals involved in the project, can be applied to other Health Institutions (in Spain or abroad).

Correspondence

Mrs María Dolores Crespo Hervás
General Public Hospital Mental Health Madrid
C/Suero de Quiñones 22,4ºC 28002
28002
Madrid
Spain
+34 6863 909 50
lolacrespo@terra.es

Integration of workplace safety and security functions as a model approach to healthcare violence prevention

Paper

Dave Keen, Donald MacAlister
Fraser Health Authority, Surrey, Canada

Abstract

This presentation explores the nature of interaction between workplace safety and protection services/ security requirements in healthcare, and problems relating to their independent development of violence prevention policy and programs. Due in part to the evolutionary growth of the approaches to safety and security specification techniques, they have largely been developed in isolation. However, healthcare systems and organizations are now being built that require integration of these functions. As a result, there is growing interest in the degree to which techniques from one domain complement or conflict with those from the other. Although there has been some work in the area of integrating techniques, this has concentrated on the techniques themselves, identifying similarities and differences, or presenting ways in which they can be brought together. The aim of this work is to investigate the nature of integration, and its influence on requirements specificati on, including discussion on methodologies for risk assessment in the safety and security domains.

The Fraser Health Authority has, since its inception, utilized a unique integrated approach between the workplace safety and protection services/security departments that have bridged the gap between the traditional approach to healthcare safety and security, including different system models used for safety and security; different documentation structures for the analyses and their results; the interaction of safety and security requirements; isolation of safety and security requirements processes.

The benefits of integration model are demonstrated through a joint process of risk prioritization, assessment and control as well as an ability to draw relevant, reliable and timely safety and security conclusions through the sharing of disparate and usually isolated data sets. By connecting the dots through integrated, real-time information from disparate sources, Fraser Health's Workplace Health and Integrated Protection Services departments provide corporate-level leadership and strategic vision to coordinate and integrate these vital programs. They are responsible for violence prevention/management policy development and technical assistance; analysis and risk assessment; corporate safety and security programs; jointly delivered violence prevention education and training; organization-wide independent oversight; and have been internationally recognized for their leadership in these fields.

Case studies will be presented on a new healthcare facility that is to be modernized in the near future, and has both safety and security violence prevention requirements. The case study will be discussed in the light of the integration framework presented, with analysis and pointers for the future direction and continued improvement in violence prevention and management in healthcare.

Fraser Health is one of the fastest growing health authorities in Canada and serve more than 18 communities and 1.5 million people. With 26,000 employees and 2,200 physicians and a .2 billion budget, our defining strength is being an integrated health organization providing a seamless continuum of care.

Correspondence

Mr Dave Keen
Fraser Health Authority
100 13450 102 Ave
V3T 5X3
Surrey
Canada
+1 604 953 5113 local 769500
dave.keen@fraserhealth.ca

Multifactorial violence in the healthcare ecosystem system: Multiple opportunities for intervention

Poster

Michael Privitera
Department of Psychiatry, University of Rochester, Rochester, New York, USA

Abstract

The following is listed pictorially top down as first associated with patient, visitor/ family of patient (pvf) and the effect of their environment upon them. Then this flows to interface of pvf with hospital staff and staff with staff as micro level, meso (institution), then macro (OSHA, CDC, Insurance Companies, then Accreditation agencies of institutions, followed by government level):

- The social needs of our culture - media violence, physical, emotional and sexual abuse, intimate partner violence, financial pressure, poverty, social injustices (structural violence), and insufficient treatment for mental illness that affects violence in those relevant.
- How can we simplify care, reduce hassles to patients (and providers)?
- Patient respect, conflict management and physical intervention skills, de-escalation techniques.
- Mutual respect and support, conflict management, team building of staff.

Awareness of a protection from risk priority of allowing sufficient staffing, reducing patient waiting times, adequate safety & patient flow design. Encourage reporting of violent events, non judgmental supportive managerial style. Advertise policy on how institution handles violence, patient and staff rights for safety, patient's right to competent care. Look beyond "Zero Tolerance" Policy as not comprehensive regarding total contributions to the problem, does not allow appropriate intervention discretion and not an effective solution.

Standardize violent event reporting tool to assist collection of comparable data sets. Fund intervention studies to determine best practice, and guidelines then to Regulatory agencies for monitoring implementation of best practice standards.
From guideline converted to mandate to incorporate key elements of guideline for institutional accreditation. Organization to acknowledge ultimate affect of WPV on staff and patient care, need to help and support individual staff victims, address organizational violence issues that are modifiable.

A separate Federal Government Agency to oversee institution of ethical best practices in healthcare insurance industry. Insurers to be accountable to ethical standards put into law; i.e., if in business of health care of individuals, then held to a higher ethical standard than other businesses denial and coverage policies transparent, abolish internal incentives for denied care (a clear conflict of interest), and eliminate provider/ patient wear-down tactics of cost control. All insurance companies, for-profit, not-for profit including state and federal, held to independent government sponsored ethical, legal, socio-cultural review of policies and standards, with public awareness of results of reviews. Ability for insurance company to operate contingent upon meeting said standards, protecting ethical patient care.

Legislative & Judiciary punish assault on healthcare staff at felony level if patient aware of right-from wrong.

Correspondence

Mr Michael Privitera
Department of Psychiatry
University of Rochester
300 Crittenden Blvd
14642
Rochester, New York
USA
+1 585 275 3592
michael_privitera@urmc.rochester.edu

Broadening the understanding of intra/inter professional aggression: A nursing managers' perspective

Paper

Isabelle St-Pierre, Dave Holmes
University of Ottawa, Ottawa Ontario, Canada

Introduction

While a safe work environment includes being exempt from aggression, health care professionals continue to identify the issue as a serious problem (Beck, 2008; Farrell et al., 2006; Shields & Wilkins, 2006). More specifically, intra/inter professional aggression is said to be very distressing to the victim, even more so than any other type of aggression (Farrell 2001; Farrell 1999). While nurse managers were identified as playing a central role in the management of workplace aggression (Alexandre, Fraser & Hoeth, 2004; Umiker, 1997), it is not clear how they deal with instances of intra/inter professional aggression given their current work environment and working conditions. In effect, the work environment and roles of nurse managers changed considerably in the last 20 years. Several nursing managers report experiencing role ambiguity and role overload (Doran et al., 2004; Thorpe and Loo, 2003); role conflict (Hendel & Steinman, 2002); limited support (Paliadelis, Cruickshank & Sheridan, 2007); and limited training (Gould, Kelley, Goldstone & Maidwell, 2001; Hynes, Kissoon, Hamielec, Greene & Simone, 2006).

Methods and materials

The purpose of this study is to broaden the understanding of how nurse managers respond to intra/inter professional workplace aggression. Based on a theoretical framework developed from the work of Girard and Weber (St-Pierre & Holmes, 2010) with the subsequent addition of work by Foucault, this study focuses on aspects of the social/cultural work environment influencing nurse managers' responses to intra/inter professional aggression as well as strategies deployed by nurse managers to deal with such aggression. Using principles from critical nursing ethnography (Carspecken, 1996), data collection included 23 semi-structured interviews (12 front-line managers, seven directors and four key informants), collection of mute evidence (including policies and procedures, codes of conducts and booklets) and casual observations of the work environment (including layout of facility, dress code, documentation posted on walls).

The study took place in two distinct organizations: a multi-site university affiliated psychiatric facility and a single site community based acute care hospital both located in a large metropolitan city in Ontario, Canada. During the study, it quickly became apparent that the environment including the culture of each organization varied greatly. Important differences were also noted in the history of both organizations, the role of hierarchy, the investment in leadership, the relationship between groups of actors, the perception of fear and risk, and the year of the implementation of organizational policies and procedures pertaining to aggression and violence.

Results

Five themes emerged from the analysis: perceptions, emotions, aggression, management and power. First, the perception of aggression was found to be highly subjective and contingent on individuals and situations. More specifically, perceptions were found to be influenced by intent (did the person believe that the aggressive act was intentional or not); differences (did the person feel threatened or at a disadvantage by the perceived differences); and representation (are expectations and assumptions leading to erroneous conclusion, is the person taking "things" too personally). Second, perceptions often generate strong emotions such as fear, frustration and mistrust. Third, aggression was described as the loss of control of intense and powerful negative emotions. Many factors both in the physical and social/cultural work environment of health care professional were found to contribute to intra/inter professional aggression resulting in various types of aggression as well as different perpetrators and victims. Fourth, nursing

managers reported deploying several strategies to deal with intra/inter professional aggression. The study also found that the management of intra/inter professional aggression often involve several actors (including individuals, peers, managers, human resources department and unions), and that people should be held accountable for their actions. Finally, in several cases power issues and power struggles appeared to be underpinning aggression. Power related to hierarchy contributed to people/professions feeling devaluated and subjugated. As well personal or hidden agendas, especially when resulting in concealed competition or the sabotaging of initiatives, were found to contribute to instances of intra/inter professional aggression.

The major study findings can thus be summarized as such: 1) aggression management is a non linear process involving managing perceptions, emotions and the actual aggressive act, which are all influenced by omnipresent and insidious power relations; 2) aggression management is not solely be the responsibility of managers but must involve several actors including the aggressive individual, peers, human resources department and unions; and 3) each individual needs to play an active role in aggression management and be held responsible and accountable for his/her actions

Discussion and conclusions

This research found that intra/inter professional aggression often occur as a result of erroneous perceptions and out of control emotions. Furthermore, the findings identified that dealing with workplace aggression can be difficult and time consuming for nursing managers. In effect, managers did not always feel prepared to deal with the issue. In some instances, they even came to question whether they were a good leader or maybe contributing to the problem. Some managers admitted doubting their abilities to be able to positively resolve such a widespread predicament.

The analysis also found that managers were more comfortable responding to instances of intra/inter professional aggression when it involved employees that they were managing. Having to deal with instances of intra and/or inter professional aggression involving staff they did not manage (e.g. staff on a float team) or staff not considered an employee of the hospital (such as physicians) proved to be more challenging. Additionally, the type of aggression also played a role in the choice of action taken. A repeat offender or someone committing a serious aggressive act (even for the first time) were often dealt with more sternly than someone for which being aggressive was out of character or that the aggressive act was identified as having little consequences.

Implications

Several implications arose from the study results. They are discussed in the context of nursing practice, education, administration and research.

Practice
As role confusion was identified as one of the reasons for both intra and inter professional aggression, there is a need for health care professionals to better understand each other's role and how they all fit together. Additionally, since the roles and scopes of practice of different health care providers often overlap, there is a need to discuss which health care provider is best suited to provide a certain type of care in a specific context. The idea of having health care providers practice to the full scope of their abilities means that while they may take on new tasks, they will also have to delegate other tasks to other providers.

The study also identified high functioning teams as having the potential to impede intra/inter professional aggression. As such, the importance of team development and team building activities was recognized. The issue of responsibility and accountability was raised on several occasions by participants. There is a need for employers to remind regulated health professionals, who are obligated to practice according to standards and codes of conducts, of their responsibilities under their professional license.

Education
The study highlighted the importance of acquiring skills in effective communication and dealing with difficult people, especially in light of the fact that these are becoming skills required by employers. As such, training on managing professional relationships, team work and assertive communication skills should be included in the entry to practice curriculum while health care professionals go through their basic education. The early acquisition of such skill would not only help students during their clinical placements since many will have already experienced aggression and bullying, but would also equip them with skills that are now required as basic competencies by many employers.

The need for ongoing training and development opportunities for both managers and front-line staff was repeatedly identified during this study. However, study participants cautioned that training should be more than an overview of theoretical concepts, especially in light of the fact that all employees have more than likely experienced some challenges with communication as well as having to respond to some form of conflict. As such, training should include case studies, scenarios and role playing opportunities where people bring examples of real life situations they had to deal with and discuss lessons learned. Whenever possible, training should also be multi disciplinary to ensure that different perspectives are heard and should include take-home materials for future reference such as tool kits or handbooks.

Administration
Several strategies relating to the hiring process were identified in this study. First, there is a need to incorporate as part of recruitment interviews questions pertaining to hospital values and ability to manage conflict. Second, "ability to manage conflict" or "possess conflict resolution skills" should be incorporated as a core competency in all job descriptions. Third, the importance of "gut feeling" and not hiring a potential candidate if someone on the selection committee has a "funny feeling" was raised. Finally, the need to keep on top of probationary period to ensure that employees who are made permanent fit well within the organization was stressed.

The issue of fairness in dealing with intra/inter professional aggression was also acknowledged during this study. Some strategies to ensure fairness were identified. For example, a "follow-through" should be ensured once a process is initiated, regardless of how complicated or litigious the issue becomes. Furthermore, the use of progressive discipline should be encouraged including suspension without pay and dismissal for extreme cases or in cases where no improvement or sustained improvement is realized over time.

Research
Future research should investigate whether taking a pro-active step toward the management of intra/inter professional aggression by actively managing perceptions and emotions before they degenerate into aggression do in fact decrease instances of aggression. Future research should also explore the issue of accountability including developing strategies to ensure that people are accountable for their actions and whether holding people accountable is in fact a detriment to acting out.

The need to invest in human resources was clearly identified in this study. However, given this time of budget cuts and constraints, human resources are often identified as costs rather than assets. As a result, further research should include a cost analysis comparing amounts saved in increased retention, decreased absenteeism, and decreased intra/inter professional aggression, to amounts required to create healthier work environment for health care professionals. As well, there is a need to include a cost analysis comparing the time (cost) currently required to retrospectively (after the event) deal with aggression, to the time (cost) necessary to (pro) actively prevent the issues.

Acknowledgements

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Correspondence

Mrs Isabelle St-Pierre
University of Ottawa
451 Smyth Road
K1H 8M5
Ottawa Ontario
Canada
+1-613-562-5800 ext. 5471
i.stpierre@sympatico.ca

Turning tragedy into policy and practice change

Paper

Wendy Fucile, Doris Grinspun
Trent University, Peterborough, ON, Canada

The historical roots of violence in health sector workplaces run deep in society, often finding their basis in deeply embedded power differentials among healthcare providers and the structures that support perpetuation of those differences.

This presentation will use a case example from Canada in which a Registered Nurse (RN) was killed in her workplace by her estranged boyfriend who was also a co-worker. Discussion will focus on the multi-strategy approach pursued by the Registered Nurses' Association of Ontario (RNAO), the professional association representing RNs in Ontario, the largest Canadian province.

We will focus on three main domains of intervention: 1) Honoring our colleague's memory through annual public events; 2) Developing an evidence-based guideline on prevention, detection and management of workplace violence; and 3) pursuing policy changes by issuing position statements and advocating for whistleblower protection and substantive structural changes to equalize the power base between the medical profession and all other health disciplines. The critical leadership of professional associations will be discussed alongside the positive outcomes achieved to date, and the gaps we continue to work on.

While the legislative frameworks governing health disciplines and health care facilities may vary from one country to another, and indeed from state to state or province to province within a country, commonalities related to the abuse of power cross all boundaries, making this a relevant and important topic to all health care providers practicing today.

Correspondence

Mrs Wendy Fucile
Trent University
1600 West Bank Drive
K9J 7B8
Peterborough, ON
Canada
+1 705 748 1011
wendyfucile@trentu.ca

Coping with physical aggression: Introduction to defensive and self-protection methods as a response to violence

Workshop

Yves Schwarmes, Jean-Marc Cloos
International Organisation of Martial Arts, Belvaux, Luxembourg

Introduction

The purpose of this workshop is to provide basic theoretical knowledge to identify aggressive behaviour and introduce the participants to defensive methods allowing optimal self-protection and escape.

The practical topics covered include:
• Security distances
• How to position oneself when being aggressed
• Anti-grappling-techniques

Rationale for the workshop

a) Violence in hospital settings

Common types of workplace violence are verbal threads (75%), physical assaults (21%), confrontations outside the workplace (5%) and stalking (2%). Coping with dangerous patients is of particular importance in the emergency department and the psychiatric wards. It is estimated that nearly 25% of public psychiatric nurses experience assault by violent psychiatric patients each year (Flannery, 2007; Soliman & El-Din, 2001). Security agents are present in most settings (98%), but often not physically available in patient care areas. A survey of 65 US emergency medicine residency programs found that only 16% of them provided violence workshops and less than 10% offered self-defence training (Behnam et al., 2010). Less than half of the evaluated emergency departments systematically screened for weapons.

General medical conditions (e.g. dementia), substance intoxication and primary psychiatric disturbances are the most frequent aetiologies of violent behaviour. Initial assessments of the patients may help to reduce the risks of physical assault. Evidence-based instruments, like the risk of violence assessment scale (ROVA), are useful to identify high risk factors for violence (Lynch & Noel, 2010). If ever possible, verbal interventions and the rapid treatment of the underlying cause should be tempted. The use of restraints and/or parenteral medication, like benzodiazepines and antipsychotics, may be needed to ensure safety and facilitate examination (Expert Consensus Guidelines, 2001). However, clinical judgment and risk assessment instruments may fail to reduce violent events, specifically in locked psychiatric settings. In these cases, knowledge of self-defence techniques may become of particular importance.

b) The Wing-Tsun method for self-protection

Wing Tsun is a 300 years old chinese martial art for self-defence. It was developed by a woman who called the style after her first student. The Wing Tsun taught in this workshop is deducted from Leung Ting. The purpose of Wing Tsun is to protect oneself in case of an assault and to be able to escape. Wing Tsun is not a fight-sport but pure self-defence! Everyone can learn it, no matter what age or gender.

The workshop pays special attention to the particular situations in hospital settings, like coping with violence in the emergency department and in closed wards, where escape is not possible and the patient needs to be quickly contained, without harming him or oneself. Topics covered by the workshop include anti-escalation techniques, security distances, anti-grappling-techniques, non-violent immobilization methods, defence techniques. Participants will learn how to position themselves in case of immediate assault, how to assist others and how to work as a team to respond adequately to violent behaviour.

The primary goal of Wing Tsun is to avoid being harmed using simple and effective moves. The soft techniques allow to control and contain a person without dangerously hurting him. The tactical moves of

Wing Tsun aim to use the arriving forces of the assault and divert it, thus making it particular useful for persons physically inferior to aggressor. The most important is not to have a collection of techniques or combinations but a global concept able to adapt to every situation.

Acknowledgement

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Correspondence

Mr Yves Schwarmes
International Organisation of Martial Arts
26, rue Wenschel
L-4491 Belvaux
Luxembourg
+352 592 898
wtlux@pt.lu
http://www.wtlux.com

Culture of Regard Program to confront workplace bullying

Paper

Pat Bradley, Chris Dunn
York University, Toronto, Canada

Abstract

Background

Bullying is the 'silent epidemic' in the workplace (DeMarco, 2002), where abusive behaviour, threats, intimidation, and other acts are not reported while draining energy and productivity. International studies have indicated that 17-76% of hospital nurses self-identify as targets of bullying (Farrell et al., 2006; Gunnarsdottir, Sveinsdottir, Bernburg, Fridriksdottir, & Tomasson, 2006; Hegney, Eley, Plank, Buikstra, & Parker, 2006; Kwok, Li, Eng, Cheung, Fung, & Pet al., 2006; Quine, 2001; Rutherford, & Rissel, 2004). Bullying in the healthcare workplace can have a broad impact on the staff psychological, emotional, and economic well-being (Cortina, & Magley, 2003; Gilmour, & Hamlin, 2003; Normanadale, & Davis, 2002). These harassment occurrences can cause anxiety and can have a long-term impact on all employees. More importantly, in these times of shortages, nurses leave the profession, thus impacting retention (Hughes, 2003; Jackson, Firtko, & Edenborough, 2002). The literature on bullying in the healthcare workplace is beginning to unfold, but there still is a paucity of research on interventions to reduce bullying. In an environment that recognizes and values respect there is no place for bullying (Tehrani, 2001).

Culture of regard strategy

This interactive presentation will discuss an intervention to develop a Culture of Regard environment to create an anti- bullying hospital workplace in Ontario, Canada. The lessons learned about developing, implementing, and evaluating an anti-bullying program will be discussed. In designing the Culture of Regard Workshops the results of a literature review and institutional needs assessment directed the curriculum. The assessment results identified the knowledge and skill gaps and these gaps focused the teaching-learning and/or mentoring. The learning environment was designed and created to be meaningful for the attendees to address bullying in the workplace. The program was built on the work by Bartholomew (2010) that considers the importance of awareness, communication, and response in addressing workplace violence and the Registered Nurses Association of Ontario (2008) healthy work environment best practice guidelines.

Evaluation measures included satisfaction with the program, and confidence and ability to use solutions to address bullying in the workplace. However, workshop attendees self-identified continuing gaps in their knowledge, skills, and judgment to create a Culture of Regard environment. In addition to the description of the Culture of Regard Program for staff and for managers, the strategies, barriers, and challenges in creating the program will be part of this interactive discussion. We will also explore future directions of this work.

Correspondence

Mrs Pat Bradley
York University
4700 Keele St.
M3J 1P3
Toronto
Canada
(416) 736-2100 x 33182
bradleyp@yorku.ca

Thai-adolescence's social responsibility toward violence

Poster

Vineekarn Kongsuwan
Prince of Songkla University, Songkhla, Thailand

Abstract

The purposes of this phenomenological study were to describe and explain Social Responsibility toward Violence among Thai-Adolescence. Fifteen participants, adolescent students were selected by purposive sampling. The data were obtained using non-participant observations, in-depth interviews in conjunction with field notes and tape recording over a period of 3 months. The Manen's method was applied for data interpretation and analysis.

Violence has increasingly become recognized as a critical social problem that requires vital attention globally, so it was valuable that adolescent students could cultivate social responsibility. It was found in 4 aspects; 1) the sensation in oneself of realizing that one is a part of society 2) the responsibility for non-used violence towards another person or a group or community including aggressive body language, verbalization of hostility, boasting to others about prior abuse, increased motor activity, overt and aggressive acts 3) self-management in troubled situations, conflict management with peers or parents, and intentional actions performed with responsibility for ethical reasons 4) how to make and respond to invitations, greet others, give and receive compliments, and ask for help.

The result of the study provided a way to learn the superior moral rank of adolescent's responsibility in solving all kinds of problems associated with violence and contributing towards a peaceful society.

Correspondence

Mrs Vineekarn Kongsuwan
Prince of Songkla University
15 Karnjanavanit Rd., Hat-Yai
90110
Songkhla
Thailand
+66 074 286571
vineekarn.k@psu.ac.th

Mental health advance directives, a way to prevent violence

Poster

Germain Droz-Dit-Busset, Yasser Khazaal, Daniele Zullino
Geneva University Hospitals, Geneva, Switzerland

Abstract

Mental health advance directives (ADs) are legal documents that allow patients to express their treatment choices for future periods of illness, when they may become incompetent. This strategy has the significant potential of minimizing coercion, trauma-related to involuntary treatments and violence in the mental health sector.

An intervention called "Advance directives based on cognitive therapy" (ADBCT) aims to assist patients in this process. Cognitive therapy interventions in the ADs creation process are based on the self determination model for adherence (autonomous regulation and perceived autonomous support); the cognitive representation of illness model and the concordance model.

A case report on the application of this model with a patient with addictive disorder was done. The theoretical background and the case illustration suggest that ADBCT is a possible way to reduce coercion and violence related problems. These results need to be confirmed in randomized controlled trials.

Correspondence

Mr Germain Droz-Dit-Busset
Geneva University Hospitals
Rue verte, 2
1206
Geneva
Switzerland
+41 22 372 55 50
yasser.khazaal@hcuge.ch

Teaching prevention and early intervention with potentially violent individuals and groups

Paper

Linda O'Dell, Wanda Shull
Veterans Health Care System of the Ozarks, Fayetteville, AR, USA

Abstract

Health care has become an increasingly violent setting for staff and patients. Teaching staff how to avoid potentially dangerous situations is a challenge for everyone. Whether the place of employment is in a city, in a rural setting, in a hospital setting, or in a community setting it is important for health care workers to be able to apply general knowledge and principles to specific situations. This may be accomplished through classes that demonstrate and practice techniques to manage a patient who is losing (or has lost control) of behavior, formal class settings, and informal discussions and applications of principles to situations. This presentation will discuss styles of learning and methods that can be utilized to enhance learning of adults.
The participant will be able to compare and contrast three teaching methodologies regarding the prevention and early intervention with potentially violent individuals and groups.

Correspondence

Mrs Linda O'Dell
Veterans Health Care System of the Ozarks
1100 North College Avenue
72703
Fayetteville, AR
United States of America
+1 479 443 4301
BeauGarreth@ymail.com

Tackling critical incident stress and workplace violence in the Irish National Ambulance Service: The role of peer support

Paper

Sharon Gallagher, Mairead. Bracken, Sinead McGilloway
Department of Psychology, National University of Ireland, Maynooth, Ireland

Introduction and background

Recent research in Ireland has shown that staff working in the Irish National Ambulance Service (NAS) have experienced high rates of workplace violence. For example, 59% (N=328) have been attacked and 40% (N=235) have had their lives threatened whilst on duty (National Ambulance Service Stress Survey (NASSS) 2008). One third of staff in the NASSS study were also identified as 'cases' on the GHQ-28 and in need of formal mental health intervention. The NAS Critical Incident Stress Management (CISM) Committee established a Peer Support Worker (PSW) service in 1998 based on the International Critical Incident Stress Foundation (ICISF) CISM model, in order to provide early support to ambulance personnel. The principal aim of this study was to assess the uptake and perceived effectiveness of the PSW service, both in dealing with CIS and other issues and problems (e.g. workplace violence).

Main Paper

Methodology

This mixed methods study was conducted in two stages. Stage one involved a postal survey of all trained PSWs (n=137) within the National Ambulance Service, whilst stage two incorporated a series of in-depth interviews with 35 PSWs.

Results

Stage One:

Almost half (46%) of the trained PSW staff were still active in their role. Eighty-two consultations were carried out during the previous year; each PSW had, on average five consultations during this period, which involved one-to-one support most of which related to Critical Incidents (CIs) (n=42). Approximately half (46%) of the consultations required referral to a mental health professional. Most PSWs (60%) felt that they were accessible to their colleagues, 45% believed the prevalence of CIS to be higher than generally recognised, whilst more than 90% indicated a need for more trained PSWs.

Stage Two:

Several key themes emerged from the qualitative analysis, four of which are discussed here. These include: PSW consultations; the importance of training; the role of management; and the service going forward. A number of barriers to service utilisation were also identified including: lack of awareness of the PSW service; confidentiality issues; the machismo attitude amongst staff; and a lack of PSW organisation and protocols. Consultations were generally informal and were related mainly to CIs, conflict issues and/or personal/family problems. A need for further training was highlighted including, in particular, stress awareness and PSW refresher training. Almost half of the participants referred to: management training; lack of communication/contact with staff; lack of support for CISM/PSWs; responsibilities in relation to training; health and safety; and the need to acknowledge 'psychological injury'. A number of suggested improvements to the PSW service were highlighted including: protocols for Control/Dispatch to flag calls for PSW follow-up; a broadcast text or pager system to notify PSWs of CIs; stress assessment for Control staff; a regular appraisal system for all staff; compulsory debriefing after suicide incidents; and a need for staff to work in teams within a regionalised PSW service.

Conclusion

The study has highlighted a number of key issues important to the future development of the PSW service and the promotion of a best practice model. The CISM model is highly regarded within the emergency services and it is commonly assumed that CISM activities, such as Peer Support, can serve a protective function by educating personnel and providing them with support and information on how to cope with workplace stress and associated factors. The challenge and responsibility for management and policy makers alike, is to minimise risk (insofar as possible) and ensure that all of those who are affected, are provided with the most appropriate and effective forms of care and support.

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Correspondence

Ms Sharon Gallagher
Principal Researcher
Department of Psychology
Room 25 Logic Annex
South Campus
National University of Ireland Maynooth
Co Kildare
Ireland
+353 87 9369378
Sharon.gallagher@nuim.ie

A little effort goes a long way: Original study of violence reduction strategies in an Emergency Department

Paper

Jacqueline Charlene Ingram, Trudy Dwyer, Leonie Mosel-Williams
Queensland Health CQU, Rockhampton, Australia

Abstract

Violence in the Emergency Department (ED) is a pervasive occupational hazard in the 21st century. Yet, there is a paucity of research into strategies and initiatives to manage violence in the health sector at local, institutional, organisational and (inter)national levels. This abstract introduces an original study that explored the frequency of violent acts reported by Registered Nurses in the waiting room of an ED before and after intervention. The intervention consisted of distributing a client-focused information leaflet. The leaflet was designed as an informative tool for use by patients and visitors to demystify the triage process, instil realistic expectations of waiting times and reinforce security measures as a deterrent to violence.

For the purposes of this research any incident involving an overt or implied challenge to one's safety or well-being was considered a violent act. Additionally violent acts were divided into five sub-categories. Factors including shift type, catalysts (alcohol / drugs / altered mental state) and the perpetrator characteristics of age, gender and role (staff / patient / visitor) were also considered.

Specifically, violent acts were opportunistically documented using an original survey tool by a convenience sample of Registered Nurses (N=34) within a one-group pre-test post-test design. Pre-test and post-test phases lasted 30 days each and generated data from a total of 92 violent acts. Ultimately, examination of pre-test and post-test group data revealed a 51.6 per cent decrease in the overall frequency of violence post intervention. Put simply, before intervention participants reported an average of two violent acts each day. Following the introduction of the client-focused leaflet, this was halved to an average of one violent incident per day.

Before and after intervention, male patients under 41 years of age perpetrated the majority of violence. It is interesting that almost 60 per cent of all violence in the pre-test phase was perpetrated by people unaffected by drugs, alcohol or altered mental state. This suggested to the researchers that perpetrators of violence are often sober and lucid and may therefore be receptive to educational intervention.

It is important to note that while the frequency of violence stemming from the perpetrator groups of 'patient' and 'visitor' decreased markedly following intervention, the perpetrator group of 'staff' was far less affected. Indeed post-intervention, 'staff' remained the source of 27 per cent of all reported violence. This is in keeping with the client-focused design of the leaflet.

Consequently, there are two main recommendations of the study. Firstly it is recommended that the leaflet intervention be instituted in the ED as an ongoing approach to violence prevention and reduction. Secondly the current study recommends that further research into the nature and prevention of staff-initiated violence be conducted.

Correspondence

Jacqueline Charlene Ingram
Queensland Health CQU
Canning street
4701
Rockhampton
Australia
+61 749 206 211
jack15@irock.com.au

Changing a culture: The shift to creating a safe workplace

Poster

Patrick Griffith, Dawn Bollman, Anne-Marie Brown
Health Sciences Centre, Winnipeg, Canada

Abstract

Violence in hospitals, particularly emergency, dialysis and mental health occurs so commonly that many health care workers, particularly nurses believe it is simply "part of the job" (Clarke, Griffith, & Brown, 2002). Increasing concern over the growing number of incidents and the seriousness of staff injuries resulted in a new culture at the Health Sciences Centre. Upon reflection, the impetus for an alternate approach to managing workplace violence resulted from a variety of local, regional and provincial factors that created an environment ripe for change.

The approach to workplace violence had been reactionary in nature and did not promote the development of proactive mechanisms. Individual incidents were responded to as they arose with the resources available at that time. In the early nineties concern about workplace violence became part of the collective consciousness of staff at the Health Sciences Centre. Regional surveys conducted in 2000 and 2001 with mental health staff on work life satisfaction, revealed a strong theme of fear and its impact on their quality of work life (Clarke et al., 2002).The survey findings provided the impetus to develop a number of quality improvement initiatives. Various strategies including the training of staff in programs such as Non Violent Crisis Intervention, paraprofessional competency training, policy development, revised occurrence reporting, quality improvement initiatives and research projects, took place. Policies such as 'searching patient belongings', and 'aggressive incidents towards employees' reflect the Centre's philosophy and intent to provide a safe, non-threatening, quality environment.

The development of policies related to workplace violence provided clear direction to the facility, and set the stage for greater involvement from the Occupational Environmental Safety and Health department. Another initiative was the development of a Violence and Abuse Free poster initially displayed in all areas of the hospital and more recently supported by professional unions to be displayed in all provincial facilities. The poster was followed up with a corresponding pamphlet that is provided to all patients on admission, that makes explicit that patients, visitors and staff are to be respected and must feel safe at all times. Other process improvements include conducting risk analyses throughout the centre resulting in multiple recommendations, installing cameras, purchasing personal alarms for staff, and developing protocols for defining minimum safe staffing levels.

In 2009, the staff on the Psychiatric Intensive Care Unit began implementing initiatives that focus on introducing the principles of recovery into an acute care setting. It is hoped that the goal of increasing mutual respect and identifying patient strengths through a variety of strategies focused on communication and providing choices, may demonstrate another potential for decreasing violence. The work of this staff group is beginning to serve as a 'model' for other units. Program management is actively attempting to capitalize on this momentum and has found creative methods of engaging and supporting these unit based dialogues. Each of these activities have been collaborative and involved various programs throughout the facility as well as external stakeholders. The belief that change is possible has seemed to result in more staff showing an interest in participating in delivering presentations on the topic locally, nationally and internationally. Patients report that our comprehensive efforts are noticed and have helped contribute to an increasing perception of overall safety.

Correspondence

Mr Patrick Griffith
Health Sciences Centre
820 Sherbrook Ave
R3A 1R9
Winnipeg
Canada
+1 204 787-3048
pgriffith@hsc.mb.ca

Physical and verbal violence toward healthcare workers in hospital emergency departments in Ankara, Turkey: A questionnaire survey

Poster

Melek Serpil Talas, Selma Akgüç, Semra Kocaöz
Ankara University Faculty of Health Science, Ankara, Turkey

Abstract

Background

Violence towards health care personnel can be seen physical, psychological, financial, social and sexual dimensions. The emergency department is an environment with much potential for violence against health care personnel, but few data have been reported in the Turkey. Gender, profession, working hours, working in the emergency department, and the educational level of healthcare workers affect faced violence.

Objective

The aims of this study were to describe the violence of emergency employees faced and their stress-dealing ways. This descriptive and retrospective study research was carried out by 270/568 (47.5%) voluntary emergency workers who work in six hospital. The data for this study were collected using a self-administered questionnaire form (consist of 41 questionnaire), based on relevant literature and the researcher's experience.

Results

Most of the respondents (83.7%- 226/270) stated that they had experienced verbal/emotionally abuse (41.1%) and physical violence (80.4%). Males, employee graduated primary school, security officers and housekeepers, employee who working at patient acceptance department and government hospital stated indicated that they had experienced more physical violence than the others (p<0.05). Also, employee in the age group 28-38 and working at patient acceptance department and government hospital indicated that they had experienced more verbal/emotional/sexual abuse than the others (p<0.05).

Conclusion

Work-related violence exposure is not uncommon in Emergency Wards. We recommend that training to deal with violence in the workplace be specifically targeted of staff who most likely to be of threats of violence and actual physical aggression.

Correspondence

Mrs Melek Serpil Talas
Ankara University Faculty of Health Science
Plevne cad.
06340 Ankara
Turkey
+90 319 14 50
talas@ankara.edu.tr

"The writing was on the wall" – coping with violence against the staff

Paper

Shoshana Shalom-Azar, Annett Liben
Shalvata Psychiatric Medical Centre, Hod Hasharon, Israel

Introduction

In this workshop we will present a model for coping with violent incidents against workers in the health sector. This will be done with the assistance of the participants in a group workshop.

1. At first we will show a short film of a workshop performed in the closed ward of a Psychiatric Hospital in Israel.
2. In the second part of the workshop there will be a warm-up exercise that will help prepare for the rest of the session.
3. In the third part the participants will be split into groups. Each group will receive a task with which it must cope.

Some of the participants will play the parts of patients and family members, and some will act as the staff – doctors, nurses, secretaries, etc.

Later, we will analyze the work done in the groups, and finally, there will be a theoretical discussion reviewing the model used.

Background

In order to demonstrate the severity of the subject which we will discuss, we will relate to some tragic incidents that happened overseas and in Israel, leaving a distinct signature of pain and frustration in the professional community.

1. On Sunday afternoon September 3, 2006 Wayne Fenton a prominent schizophrenia expert and an associate director at NIMH was found dead in his office. He had just seen a 19-year old patient with schizophrenia who later admitted to the police that he had beaten Fenton to death with his fists (18).

2. In Israel, a previously diagnosed psychiatric patient who had been treated in the Kiryat Yovel Mental Health Services Clinic in Jerusalem, came into the clinic on the 8th of September 1992 with a loaded automatic gun and in a crazed attack murdered four women workers.

These tragic incidents raise, once again, the controversial question about the potential danger posed by people with mental illness. The killings also left many in the mental health and medical communities concerned about their own safety in dealing with psychotic patients. It is natural for psychiatrists and other medical professionals who treat psychiatric patients to deny to some extent the possible danger. Still, we need to remind ourselves that the risk of violence, though small, is real, and we must take necessary precautions. (18)

Workplace violence is an area of national concern. According to the Bureau of Labor Statistics, 2637 non fatal assaults on hospital workers occurred in 1999- a rate of 8.3 to 10000 workers, higher than the rate assaults for all private sector industries that are 2per 10000 workers.
Nurses, physicians and advanced practice professionals reported the highest prevalence. Among non clinical job types secretaries (who have patient contact as part of their position) had greater prevalence of threats and assaults than their counterparts who do not have patient contact.
Nurses working with people with mental health problems are twice as likely to be assaulted as nurses working in general hospital settings. (16)

Are people with mental illness really more likely than others to engage in violent behavior? If so which psychiatric illnesses are associated with violence, and what is the magnitude of increase in risk?
Without a realistic understanding of this risk medical practitioners cannot provide the best care for their own safety when the clinical situation warrants it. One national survey showed that the lifetime risk of schizophrenia was 5% among people convicted of homicide –a prevalence that is much higher than any published rate of schizophrenia in the general population .The data showed that there is a significant

statistical connection between mental illness and the risk of violence. A mental health patient has a higher risk of violence, 4-6 times as much as in the general population. Further, it was found that women with mental illness were prone to violent incidents more than men.

 In absolute terms the lifetime prevalence of violence among people with serious mental illness was16%as compared with 7% among people without mental illness.

It is natural for psychiatrics and other medical professionals who treat psychiatric patients to deny to some extent, the possible danger. After all, it is hard to have a therapeutic relationship with a patient we fear (9, 18).

The most common conflict behaviors on the part of patients where verbal aggression, refusing regular medication, refusing to see workers, and attempting to abscond.

Violence to self, others, and verbal abuse are the four classic dimensions of most violent incident scaling methods. (4)

Violence and aggression in the workplace is a significant problem in Germany and in other countries.

In a German survey, violence and aggression are defined as: Incidents where staff are abused, threatened, or assaulted in circumstances related to their work. In this context violence can include any form of verbal, physical and sexual aggression and/or physical violence.

In the twelve months prior to the survey, verbal aggression was experienced by89.4% of the participants, and physical aggression by 70.7% employees in psychiatric clinic78.7% and 83.9% in nursing home. Nursing staff 78.3% stated that they had been victims of physical aggression compared with 45.5%of those employed in pedagogic position.

This study was designed especially to examine the relationship between ward occupancy level and staff –to-patient ratios and violent incidents, either physical or verbal, in an acute psychiatric ward.

The hypothesis was that increase in the number of violent incidents would be positively associated with a low staff to patient ratio and with high ward occupancy. (11)

The ability of clinicians to assess potential for aggression is still limited. Despite recent advances, actual risk assessment has as yet yielded neither accurate nor practical violence risk prediction. The violence risk assessment literature (1, 2, 7, 15, 21, 22) has focused both on patient clinical, contextual and historical factors empirically associated with aggression.

Only about 60.3% of the staff reported violent incidents. 11% of the staff who had been hurt needed some level of medical treatment. Furthermore, about 80% of the staff hurt, showed emotional responses of anger, helplessness and anxiety. 64% reported that they are now more careful at work, 34% reported continued feeling of anxiety, fear and unpleasantness at work for a long time following the violent incident. (1, 2, 7, 15, 21, 22)

In order for an environment to be truly "safe" it must be physically, psychologically, socially, and morally safe for everyone in the community. The achievement of that level of safety can though only be reached by means of a shared process over time. (3, 11)

The inpatient ward environment, treatment programme, and staff should be structured so as to prevent violence. There should also be educational programmes for staff not only in the use of physical restraints but in the sensitive, non-provocative use of verbal means of dealing with violence, or impending violence. The staff should be caring and non- authoritarian, yet be able to set limits in regard to the patient's behavior. They should be available to talk with and listen to the patients. It is important that the staff recognize the warning signs of violence for an individual patient. In managing violence by patients one must consider the balance between medication, seclusion, and restraint. A patient should never be secluded or restrained for the convenience off the staff (20).

In Israel the changing point relating to violence to staff came about after a violent incident against a doctor in 2008. A Senior Orthopedic doctor in the Kaplan hospital was stabbed with a screwdriver by a patient who he had been treating for a long time. The patient, who was frustrated and dissatisfied with his treatment on that specific day, severely attacked the doctor and left him with irreversible injuries. This incident became the seminal example on the subject of violence towards staff in Israel. The regulator and supervisor, namely the Ministry of Health, and Clalit Health Services, the employer, appointed a committee on this subject. Further to this committee's conclusions, it was decided, amongst other things, to organize workshops for the staff in all the hospitals of Clalit Health Services, on how to cope with violence in the workplace.

An instruction manual was published with tools for coping with violent incidents, with the main issue being More control and less restraint – guidelines in coping with violence (7).

Many articles were written on the subject of programmes for coping with violent patients (8, 10, 12,14). But these articles lacked standardization of structured programmes with the aim of guiding medical staff on how to cope with these situations. Some recommended establishing a unique tailored programme for dealing with violence according to the specific needs of the staff.

We therefore took upon ourselves to establish such a programme, which we wish to present here. This model is multi-sector departmental and is based on presentations and discussions of authentic incidents that occurred in the departments.

Goals

1. Developing staff skills to reduce violent episodes by using preventive measures.
2. Developing skills to identify potential situations of violence.
3. Developing skills that will enable minimal psychological and physical damage in violent situations.
4. Developing skills for support of those injured.
5. Developing skills for investigating the incident and drawing conclusions.

Methods

First stage: The workshop instructor meets with the medical director and nursing staff of the department. In this meeting, the instructor presents the goals of the workshop and asks the directors for several examples of frequent incidents of violence in the department. Furthermore the instructor requests the presence of four staff members, who can play the roles in the incidents chosen. In his choice, the instructor emphasizes that some of the incidents consist of violent events in which family members are also involved.

Second stage: The instructor works with the members of staff "actors" and guides them on the events that they will present in the workshop – enactment. Working with the staff who will act the different parts is crucial. The emphasis in working with the "actors" is on how they will perform – aggressively, both vocally and physically, physical resistance, emotions, cursing, etc. During the performance the instructor may communicate silently with the actors, therefore becoming the "stage director." These directions are done in response to the staff's reactions to the incident being acted out.

Third stage: The workshop. Before the department staff arrives, the "actors" and instructor prepare the scene, bringing in a bed, restraints, and other equipment that may be needed for the enactment. Although the scene is based on real events, the dramatic enactment can change according to the response of the staff and how they cope with the situation.

It is a group, staff, departmental activity. Every meeting is opened with a lecture by the department director on the subject of coping with violence, focusing on relevant subjects concerning the department in question.

By starting the workshop with the department director the message forwarded is – "I am the Director, I am responsible, I have the knowledge needed on the subject and I am your resource."
Following this is the activity demonstrating violent situations previously chosen. The members of the staff are divided into groups according to the number of incidents presented.
Each group receives written guidelines regarding the incident and parameters for analyzing it. The group is given time to prepare itself for the enactment - everyone is given a part. The instructor then declares when the enactment should start.

After presenting all the incidents, there is group analysis on how the staff coped and felt during the situation, both as participants and as observers. Some of the points that will be discussed:
• What did you learn about yourself from the incident?
• Signs leading up to the incident.
• Negotiations
• Interpersonal communication with other members of the staff, etc.

At the end of the workshop, there is a theoretical discussion, based on observation and relevant literature on the subject (7)

Evaluation of the workshop is performed after each workshop through questionnaires provided by an external party, related to subjects such as: satisfaction from the workshop, its contribution to decreasing violent incidents, identifying possible violent situations, personal safety, etc.

Discussion and results

In order to improve the ability of the staff to prevent violence and cope with it, unique workshops were planned and implemented. In general, 87% of the staff evaluated that the workshop contributed a lot to the ability to cope in violent situations. 83% felt that they received good tools for effective communication in order to prevent violence, and tools to identify possible situations that could evolve into violent ones. Furthermore, 80% felt improvement in their ability to work through potentially violent situations in order to prevent their escalation, as well as their ability to better cope with verbal as well as physical violence. 92% of the participants felt that they had been provided with tools enabling them to identify situations before they escalated into violence. Satisfaction from the instructions during the workshop was good.

As a result of the workshop, the participants felt improvement in their sense of personal safety at work. They also felt that having the workshops proved that their organization understood the importance of the physical wellbeing of their employees, and worked to lower the incidents of violence against them. In a survey done by Clalit Health Services in 2009 on the subject of personal safety the respondents marked 8.17 compared to 6.18 in 2008. Clalit Health Services Head Administration emphasized that this was most probably the result of these workshops.

From evaluating the results of the analysis, we found that most of the goals of the workshop had been reached, and skills for coping with and identifying violent situations were acquired. We found that the staffs' feeling of safety in the workplace is a prerequisite for high quality of work. We see this workshop as an essential part of the process and therefore we continue to have additional workshops by request from the various departments. It is our opinion that the success of this model was brought about by the fact that all the staff work as an interacting unit, with all staff members being involved in the process – from the department director to the secretaries – all those who meet the patients during their everyday jobs. With this attitude the departments can become a safer, unified place for both staff and patients.

Acknowledgements

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Correspondence

Mrs Shoshana Shalom-Azar
Shalvata Psychiatric Medical Centre
Aliyat Hanoar
P.O.Box 94
Hod Hasharon
Israel
972-9-7478693
shoshsh@clalit.org.il

From workplace to workplace – national sharing of knowledge

Poster

Hanne Juul Nielsen, Birgitte Baekgaard Brasch
Social Development Centre SUS, København, Denmark

Abstract

Background

Social Development Centre SUS has since 1992 been engaged in the work with prevention of violence at workplaces, especially during national campaigns in the public sectors of social welfare and health. During these efforts SUS has build up close contact to many working places which have achieved substantial resultants in preventing violence. The noticeable results have been reached during intensive focus on development of professional competences, user participation, guidelines, the physical environment, technical equipment and various methods in the cooperation with the users. The experiences from the working places in the front with the development are being passed on to other workplaces in the sectors of social welfare and health in many different ways of communication. SUS communicates the results during meetings for network, thematic meetings, seminars, conferences, on the website www. voldsomudtryksform.dk and during projects for other workplaces.

Yet – still is much to be done. Quite a sum of workplaces is not updated with the development. Our goal is to involve and inspire the workplaces with the god stories from the success that others have achieved.

Method

The method is to be developed in 4 phases. It is important, that the starting point in the local initiatives is set to the every concrete workplace. Also it is vital that the staff recognizes the problems and can relate the solutions to exactly their own situation of work. The prevention of violence can be done in many different ways, due to the users and other local conditions. At the same time the actual knowledge and good experiences shall be involved.

We talk about four phases in development projects in working places:
1. Survey of needs,
2. Analysis of the survey and decide the initiatives,
3. The process are completed,
4. Evaluation, gathering of experiences, adjustment.

For this purpose the workplaces use an electronically questionnaire developed by SUS. Every member of the staff answers the questions that concern violence and the physical and psychological work environment. The answers are anonymous and shows how satisfied with the work prevention members of the staff are. At the same time it occurs where new efforts are needed.

1. Survey of needs and decide initiatives
Leaders and the representatives of the employees make analysis of the results from the survey and make in community the concrete plans for what is to be done. Involvement of the employees is essential for the achievement of ownership and to make the effort as efficient as possible.

2. The process is carried through
Sufficient time for the process and for the implementation is often needed. Especially in the cases, that means change of attitudes, working procedures and culture of the workplace. It is an important point that the workplace doesn't have to invent the whole setup and all solutions by its own as there is already a bunch of knowledge and opportunities. This knowledge is reused by and adjusted to the new projects. Projects that involves fx better written guidelines, new procedures, knowledge about how to handle crisis, registration of treats and violence, use of supervision etc.

3. Evaluation, gathering of experiences, adjustments

A project divided into phases appears on first hand very linear, but is doesn't have to be that way. During the process of development is important to meet and to discuss experiences and continuously to evaluate and adjust the efforts and the goals. When all of the processes have been landed and been implemented, the project are final evaluated. Again the leaders and the representatives of the employees meet for at mutual discussion about the project: Did we reach the aims for the project? In the evaluation can be based on both qualitative data with interviews with employees and users/relatives and on quantitative data, fx absence due to illness, the number of violent episodes and a final comparable survey.

The project has come to an end, but not the efforts for prevention violence at workplaces. It is of great significance to keep focus on the violence and the work environment.

Correspondence

Mrs Hanne Juul Nielsen
Nr. Farimagsgade 13
Social Development Centre SUS
Nr. Farimagsgade 13
1364
København K
Denmark
+45 3393 4450
hjn@sus.dk

Strengthening social dialogue with emphasis on management of emergency situations of violence at workplaces, above all in health- and social care institutions

Poster

Jirí Schlanger & Ivana Břeňková
Trade Union of Health Sector and Social Care of the Czech Republic, Prague, Czech Republic

Abstract

This project is aimed at strengthening social dialogue with emphasis on management of emergency situations of violence at workplaces, above all in health and social care institutions. The outcome of the project would be above all 60 trained specialist-certified lectors, coordinators, coaches, methodologists, consultants and negotiators of workplace violence issues. Eight hundred people would be trained in special certified courses - these people will gain an overview of the workplace violence issues and will be able to act and intervene in crisis situations. Our certified course would have 4 modules – 1) General problems of workplace violence and the legal context, 2) Psychological aspects of workplace violence and crisis communications, 3) Fundamentals of self-defence, and 4) Management of workplace violence prevention and are part of the educational activities of professional and continuing training of health professionals.

Correspondence

Mr Jirí Schlanger
Trade Union of Health Sector and Social Care of the Czech Republic
Konìvova 54
13000
Prague
Czech Republic
+42 267 204 312
Schlanger.Jiri@cmkos.cz

Nursing the hurt of survivors: Lessons learned from a community collaborative initiative

Paper

Jessy Haywood
The Center for Women and Families, Louisville, Kentucky, USA

Introduction and Background

In 2005, The Center for Women and Families (CWF), in partnership with Indiana University Southeast Department of Nursing, launched the Nurses Exchanging Training and Service (NETS) program in the Kentuckiana region of the U.S. Today, NETS brings together nursing education programs at this University as well as those at Galen College of Nursing and the University of Louisville with CWF, our region's sole intimate partner violence (IPV) service provider, to equip nursing students to better respond to victims of IPV in healthcare settings through an innovative, service-learning exchange. Nursing students are provided with education on IPV and in-turn, provide volunteer hours responding to victims as advocates in the emergency setting.

There is a great deal of evidence which served as the impetus for such a project. Nearly one third of women in the U.S. (31 percent) experience physical and/or sexual abuse at the hands of a current or former intimate partner in their lifetimes.[1] There are strong indications that healthcare providers generally, and nurses particularly, can play a significant role in uncovering the presence of IPV in the lives of their patients, improving the safety of victims, reducing incidents of IPV and reducing the healthcare costs of IPV including monetary cost incurred by healthcare institutions.

It is known that nurses frequently interact with patients experiencing IPV, particularly in the emergency setting. Researchers have found that abused women and their children use health care services 6 to 8 times more frequently than their counterparts not experiencing abuse and of all women seeking care in hospital emergency departments for injuries caused by violent trauma, 37 percent of them were injured by a current or former intimate partner.[2] In addition to the obvious and very high human cost, there are monetary costs associated with IPV. It is estimated that U.S. healthcare institutions spend in excess of 5.8 billion dollars annually on expenses related to IPV, 4.1 billion on direct mental and medical healthcare services alone.[3] There is also research emerging which indicates that healthcare costs can be reduced by at least 20 percent when hospital staff intervene in patients' experiences of IPV.[5]

Nurses are well-positioned to detect IPV in the lives of patients. One study found that over one third of abused women who had disclosed the violence to someone (37 percent) made the disclosure to a healthcare provider. This rate of disclosure to health care providers exceeded rates of disclosure to IPV service providers, law enforcement, friends and even family members.[5] Disclosure however, is not often spontaneous. Another study found that 36 percent of women surveyed said they would only disclose abuse if a healthcare provider directly asked them. [6] When educating patients on options and resources is considered a necessary part of any effective screening measure, the role of such intervention in the lives of abused women becomes even more important. The same study found that only 36 percent of women surveyed were aware of the resources in their community relevant to IPV. [6] Additionally, screening goes a long way in helping victims of IPV to be safer. For this reason, healthcare screening for IPV is often regarded as a vital secondary prevention effort. Researchers have found that some 10- and even 2-minute screening and intervention efforts made by healthcare providers create drastic increases in the safety of abused women.[7, 8] If healthcare providers do not detect or address potential IPV, it is far more likely that abused patients will return to dangerous situations, often without knowledge of community resources, options for escaping violence, care for psychological and emotional impact of violence, or documentation that violence was ever perpetrated in the first place.[9, 10] If visits to a healthcare provider are due to an increase in frequency and/or severity of violence used by the woman's partner, there is a 50 to 60 percent greater likelihood that the abuse will result in homicide.[11]

All of this research speaks to the need to equip healthcare providers with the knowledge and skills necessary to both detect and respond to IPV in the lives of their patients. The reasons for targeting nursing students

were two-fold. First, there is some indication that nurses are better positioned to screen for and respond to IPV than other types of healthcare providers. Researchers have found that female victims of IPV are far more comfortable discussing such violence with a female healthcare provider than with a male healthcare provider.6 Because most victims of IPV are female (85 percent in the U.S.) and because most nurses are female (94 percent in the U.S.), it simply makes more sense demographically to target nurses (especially when compared with doctors who are 25 percent female in the U.S.).[12, 13] Additionally, one study found that particularly in the emergency setting, nurses are more likely than doctors to be the ones doing this type of screening with patients.[14]

Second, nursing students were targeted as a matter of readiness and access. While nurses are already responding to victims of IPV, their demanding schedules often preclude any time for volunteering or for continuing education beyond that which is mandatory. We, at CWF, had already been targeting registered nurses for training and for volunteer recruitment, with limited success. Students in nursing programs, by contrast, often had time available to devote to such a project. Since educational content could be incorporated into normal class time, there would be no additional time-demands placed on the nursing students. We also found that nursing students were already being asked to volunteer at agencies in the community as part of an approach to nursing education called community health nursing. Community health nursing encourages nurses and nursing students to spend time in the communities they serve, becoming more familiar with community composition, values and residents, with the goal of improving the health of that community and of vulnerable populations. It has become a greater and greater focus of nursing programs in the U.S. generally and in the Kentuckiana region specifically.[15] At the launch of the N.E.T.S. program, there was renewed willingness at the University-level to partner with community service providers as a way of equipping nursing students to be effective nurses. Additionally, we had already been given access to educate students at the only medical school in our region, that at the University of Louisville. While medical students are not afforded as much time in their schedules to engage in community work as nursing students, the educational experience has been valuable nonetheless. Given the access and readiness issues present at the time of the program's inception, nursing students emerged as the best partners in this endeavor.

Program Implementation

The NETS program was born out of an existing, partnership between CWF and Indiana University Southeast in New Albany, Indiana in the U.S. For years, CWF had been visiting freshman classes at the University to educate in-coming students on IPV and sexual violence. Additionally, the University had long been referring students, faculty and staff members experiencing IPV or sexual violence to CWF for secondary and tertiary prevention services. In 2005, the volunteer manager at CWF approached the then-chair of the department of nursing at the University to pitch a training and volunteer partnership. The University and CWF then established a memorandum of understanding (MOU) for the project. CWF is a member of four state-wide coalitions, the Indiana Coalition Against Domestic Violence, the Indiana Coalition Against Sexual Assault, the Kentucky Domestic Violence Association and the Kentucky Association of Sexual Assault programs, all of which maintain regulations regarding number of training hours needed before any volunteer may work with a survivor of violence. To meet the regulations of all of these state-wide coalitions, the MOU established a minimum of 12 training hours be provided to each student. In exchange, each student would provide a minimum of 12 volunteer hours to CWF.

CWF has long provided advocacy to victims of IPV in the hospital emergency setting. Such advocacy consists of providing support to the victim in the hospital, explaining what the victim might expect, helping the victim to create a safety plan and helping with any basic needs like food, water, blankets, etc. Advocacy is provided on an on-call basis. CWF has established MOUs with hospitals in its service area which state that anytime IPV or sexual violence is indicated with a patient, the hospital will contact CWF to request an advocate. The University and CWF determined that serving in this capacity as a volunteer would be of the most benefit to the students and to the mission of CWF. The 12 volunteer hours would be spent on-call to respond to the hospital.

The CWF training team developed the educational content for students in consultation with nursing professors. The following training outline was developed for the program: I. Introduction to CWF (45 minutes): mission and vision of the agency, services, scope of the work; II. Understanding the dynamics of IPV (165 minutes): practical and legal definitions, power and control wheel, scope of the problem, experiential exercises and case examples; III. Understanding the impact of IPV on children (90 minutes): how children are exposed, effects of exposure, scope of the problem; IV. Understanding the dynamics of sexual violence (120 minutes): practical and legal definitions, victim's experience, intersection with IPV, scope of the problem, experiential exercises and case examples; V. IPV and legal justice (60 minutes): understanding criminal and civil implications of IPV, understanding forensic response, understanding law

enforcement response, how to interact with law enforcement; VI. Understanding the advocate's role (180 minutes): what to expect at the hospital, what to say to survivors, what to do for survivors, practice and role play, necessary forms, mandatory reporting statutes; VII. Responding to student questions and concerns (40 minutes); VIII. Breaks (20 minutes).

Students coordinate volunteer shifts with the volunteer manager at CWF. Each student may choose any 12-hour shift during the current semester that fits their schedule. Students are then placed on the regular volunteer rotation for hospital on-call shifts. If advocacy is needed for a survivor in the hospital during the student's shift, CWF contacts the student at home to request immediate response. If a student does not answer when called or refuses to go to the hospital to provide advocacy, CWF contacts a back-up staff member to respond. The lack of response is then reported to the nursing department and the student receives a failing grade for the project.

Feedback is taken from students after the training session. Additionally, students are encouraged to call the crisis phone line at CWF after responding to the hospital in order to process the event with a crisis counselor. CWF also remains in constant communication with the university's nursing department so that any feedback can be received and concerns about the students' roles addressed.

Initial feedback indicated program success. Students said they increased their knowledge about IPV, gained skills in responding to IPV and increased their comfort and efficacy using those skills. After this initial success, CWF was able to add two additional nursing departments to the partnership; those at Galen College of Nursing and the University of Louisville.

Results

Earlier this year we conducted a survey with students who had recently completed the NETS program (n=37). Students were asked to rate their experience before and after participating in NETS, on a Likert scale from 0-5 for the following factors: comfort responding to victims in the hospital setting (0= very uncomfortable, 5= very comfortable), empathy or compassion for survivors of IPV (0= none, 5= an extreme amount), knowledge about responding to survivors of IPV (0= no knowledge, 5= comprehensive knowledge), skills efficacy in responding to survivors of IPV (0= none, 5= completely efficacious), knowledge of resources available to survivors of IPV (0=no knowledge, 5= comprehensive knowledge), and likelihood to consider working as a sexual assault nurse examiner (SANE). We hypothesized a significant increase on all scores. Increasing likelihood of students to consider working as a SANE was not an original goal of the program, however after receiving feedback to this effect from students who had completed the program, we saw it as an ancillary benefit and assessed for that factor as well. Using a t test statistic (dependent) to compare pre- and post-program scores, we found the following results, for all of which p<.01: comfort t(36)= 8.07, empathy/compassion t(36)=5.24, IPV knowledge t(36)= 10.46, skills efficacy t(36)= 10.97, resource knowledge t(36)= 10.41, SANE likelihood t(36)= 6.05. Increases on all factors measured were significant. We were able to prove our hypothesis about the program, with the greatest increases found in knowledge and skills efficacy when responding to survivors of IPV and knowledge of resources available to survivors. We found a less significant increase in empathy or compassion for survivors, however this seems to be due to fairly high scores on the pre-program measure of this factor, mean=4.08. This did not allow for much upward movement in the post-program measure. See figure 1, below, for a comparison of pre- and post-program mean scores.

Figure 1. Mean Scores Pre v. Post
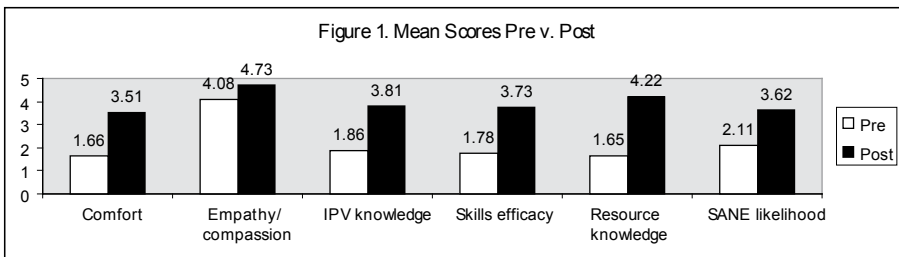
Successes and Challenges

We have faced some challenges in implementation of the NETS program. We have also learned a great deal about the benefits of the program for students. The choice to host training sessions at CWF, for example,

has emerged as advantageous. We have found several students are currently experiencing or have previously experienced IPV. Some even report an inability to identify abuse in their own relationships until the dynamics are defined and explained in the training. Many students are able to recognize the early indicators of power and control in their relationships which are often the precursors to violence. Because several students first make this realization during the course of the training and/or have strong emotional reactions due to current or previous experiences with IPV, immediate crisis counseling becomes necessary. Because the training is hosted at the CWF location, we already have advocates on-site who are prepared and able to respond to these students immediately.

There is also a great benefit to CWF staff which became evident at the on-set of the program. Because a large pool of volunteers are added to the hospital on-call schedule at one time each semester, staff who previously responded to hospital calls outside of their normal working hours are able to remain at home while a volunteer advocate responds to the hospital. This provides some relief to our staff and helps to reduced some of the vicarious trauma inherent in the work.

The program of course is not without its challenges. For some students, for example, location is a challenge to providing timely hospital response. The ideal response time from when the hospital makes the call until an advocate walks into the emergency department is 20 to 40 minutes. For students who live very far away from the urban centers where hospitals are located, this is impossible. This problem has been addressed by asking the students if there is a place they can stay, close to the hospital, during their on-call shift (for example, spending the day with a family member in-town). If this is not possible, students are provided with another volunteer opportunity which does not require them to be on-call, including providing child care at CWF during support groups or helping to prepare and serve meals to residents at CWF's shelter. Although these options do not afford students the opportunity to use the advocacy skills they have learned, it does fill a volunteer need and at least gives the students the opportunity to interact with survivors at some point in their healing process.

Gender also serves as a barrier for some students. It is a policy of CWF as well as the state-wide coalitions to which it belongs that a male advocate may not respond to a female victim in the hospital. While male nursing students can still be placed on the hospital advocacy on-call schedule, they can only be called if a male victim is presenting at the hospital. Since this is very rare in cases of IPV, male students often never have the opportunity to respond at the hospital. The back-up staff person at CWF is called any time a male is on the schedule but a female is needed at the hospital.

We also continue to face the challenge of expanding the program to other nursing departments. Three additional, accredited nursing programs in our service area have not adopted the NETS partnership. Requests to join the NETS partnership resulted in one program's willingness (Bellarmine University, Department of Nursing) to have CWF educate its students on IPV, however the amount of training time is limited and students do not provide volunteer service hours in exchange. We have tried to increase the likelihood of these programs to join the NETS partnership by working to build relationships with their faculty and staff. We have participated in health fairs for these programs by setting-up tables, remained in contact with their staff to discuss future opportunities, and have invited them to events sponsored by our agency. It is our hope that these efforts will contribute to a decision by these programs to join the NETS partnership.

Conclusion

From the perspectives of CWF and the nursing programs with which we have partnered, NETS has been a success. The support provided by the students' volunteer hours has made a tremendous impact on our ability to provide sufficient and comprehensive services to survivors of IPV. Nursing students have emerged from the program equipped with the knowledge, skills, comfort and empathy so essential to effective response with survivors of IPV. Not only have the survivors to whom students have directly responded in the emergency department benefited from the program, but given the high rate of exposure to victims of IPV experienced by nurses and the potential impact nurses can have on the safety of victims, the program will continue to be a benefit for survivors for decades to come.

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Correspondence

Mrs Jessy Haywood
The Center for Women and Families
P.O. Box 2048
40201
Louisville, Kentucky
United States
+1 5025 817 200
jessy.haywood@cwfempower.org

The relationship between mobbing and co-dependency in nurses

Poster

Gülsüm Ançel, Elif Yuva
Ankara University, Faculty of Health Sciences, Ankara, Turkey

Abstract

Objective

Mobbing, defined as emotional assaults at workplaces, is associated with bullying and stalking. Co-dependency is a treatable problem and it is nearly impossible for co-dependents to say 'no' to people, therefore they may find themselves the victims in physically and emotionally abusive relationships. Since there was no study for identifying the relationship between mobbing and co-dependency this descriptive study was conducted.

Method

The data were collected from 96 nurses who employed in a university hospital. Approval was obtained from the university. A questionnaire, Mobbing Scale (Yýldýrým & Yýldýrým, 2007), Co-dependency scale (Hughes-Hammer et all, 1998) and since depression was the dependent variable for co-dependency, Beck Depression Inventory(Beck, 1961) were used for data collection. SPS 15.0 was used for statistical analyses. After descriptive statistics Chi-Square and T Test were used. P values less than 0.05 were considered statistically significant. Cronbach's alpha reliability coefficients were calculated for all scales.

Results

All nurses were female and their mean age was 33.01 years with job experience of 12.6 years. The majority of them were married (66.7), had under baccalaureate degree (62.5%), worked at inpatient units (68.8%). Cronbach's alpha reliability coefficients were found .92 for Beck Depression Inventory, .85 for Co-dependency Scale and .95 for Mobbing Scale.

The results indicated that 13.5% of the nurses had been exposed to mobbing in the last 12 months and experienced mobbing from co-workers and administrators respectively. Correlations revealed that mobbing was negatively associated with job experience in nursing (P=0.035). It was found a strong and positive relationship between co-dependency and mobbing (P < 0.01). It can be recommended that managers in hospital should take these findings into account in order to decrease mobbing and co-dependency. Further study is needed to generalize the results.

Correspondence

Mrs Gülsüm Ançel
Ankara University, Faculty of Health Sciences
Plevne Cad.Aktaþ Kavþaðý
06080
Ankara
Turkey
+ 90 312 319 14 50
ancel@medicine.ankara.edu.tr

Registered nurse mentoring and shared governance with executive management to address hostile behavior and incivility

Paper

Christine Latham, Karen Ringl, Mikel Hogan
California State University, Fullerton, CA, USA

Abstract

Research objectives

1) To synthesize focus group data for case exemplars of nursing student and working staff perceptions of incivility and hostile interactions in service and academic settings, and 2) to evaluate new mentoring and governance interventions with both groups of nurses to foster more supportive learning and work environments.

Method

Using a multi-trait, multi-method approach, two participant groups of 287 staff nurses and 103 student nurses underwent mentoring education. Nursing staff included 116 mentors and 171 mentees that resulted in132 mentor-mentee teams. Nursing student participants consisted of 24 RN-BSN, 48 generic and 31 pre-nursing students enrolled in baccalaureate coursework. Following consent processes, the first phase of this research consisted of conducting focus groups. A content analysis process was used to determine events that impact nurses' education and incorporation into the workforce. Subsequent interventions included mentoring classes for all participants and support and shared governance meetings for hospital nursing staff. Focus group data revealed that newly-hired RN mentees had significant issues that interfered with their incorporation into the workforce and these factors sometimes led to dissatisfaction and/or seeking new employment. These issues were discussed with executive management at each facility in a Workforce Environment Governance Board. All hospital-based RN mentors and newly-hired RN mentees also completed questionnaires about shared governance and the professional practice environment. Similarly, focus group work to determine incivility and other barriers to success in a baccalaureate nursing education program were completed with 103 student nurses who anticipate being hired into regional hospitals upon graduation. This data revealed that students felt stressed and perceived a lack of support, especially from family and friends outside of school. Students also revealed a lack of support by faculty and working nurses during clinical rotations.

Results

Results indicate that student nurses and newly hired registered nurses (mentees) encountered stress, lack of self-confidence, poor support from non-school peers, and perceptions of disillusionment, disappointment and detachment as a result of their education and workplace experiences. Questionnaire results verified some of the issues with incorporating new RN staff. The Decisional Involvement Scale (DIS) data indicated significant DIS differences of mentor perceptions of the existing and desired level of shared decision making (with administrators) about nursing practice following mentor education. Following input from mentees, mentors wanted more administrative support for unit-based conflict resolution and assistance with negative physician relationships (t= 2.426, p = .009) and also changed their perceptions of the need for additional administrative oversight of the quality and scope of practice of support staff practice (t = 2.002, p = .024). Additionally, post-mentoring data based on the Professional Practice Environment Scale (PPE) indicated that mentoring improved staff nurses' ability to work in teams (t = -3.045, p = .001) and enhanced their ability to handle disagreement and conflict (t = - 1.890, p = .030). Peer mentoring, both during nursing education and in the early hiring period following graduation, seems to be an important mechanism to dissipate stress, resolve conflict from inhospitable interactions while engaged at work or in education endeavors, and dispel perceptions of low self-confidence, disillusionment, disappointment, and detachment that can result in leaving the workplace and/or the nursing profession.

Correspondence

Mrs Christine Latham
California State University
800 State College
92834-6868
Fullerton, CA
USA
+1 657 278 2291
clatham@fullerton.edu

Commonalities in maximizing safety in various human service sectors

Paper

Bob Bowen
The Mandt System, Inc. Richardson, USA

Abstract: Reducing violence in healthcare settings has received attention in medical, psychiatric, criminal justice, and developmental disability service sectors. Research has been centered on each service sector individually, with little if any communication between researchers and practitioners across boundaries. Commonalities between approaches to reducing violence towards service users and service providers in these sectors include leadership, the use of positive behaviour support, benchmarking with strategically developed goals, trauma informed services, and the importance of relationships which underpins all these common themes. The differences between correctional programs, schools, group homes and psychiatric hospitals have more to do with the organizations than the people served by the organizations. Most, if not all, are people who have been wounded, and need the support, assistance, and professional care of staff to achieve their goals. The commonalities of human services are seen in the people, and as such, people can benefit from positive behaviour support and trauma informed services when leaders set benchmarks strategically and then guide the organization towards the goal of eliminating violence in human service settings.

Relationships

The relationships between staff at all levels of an organization is the context in which all human services are provided and received. When these relationships are controlling and coercive, human services are provided and received in controlling and coercive ways. The tools of Positive Behaviour Support, the conceptual understandings of Benchmarking and Trauma Informed Services, and the interactions of leaders with all the stakeholders in an organization, are all influenced by the quality of relationships between the staff in the organization.

Herzberg's Motivational Theory (Herzberg, 1954) discussed motivating factors for employees. A deeper understanding of the theory reveals that the "platform" for successful implementation of motivational tools are relational in nature (Chapman, 2003). When relationships with others are sound, it is easier to implement the conceptual and technical tools used in human service organizations (Mandt et al, 2010). Understanding the centrality of relationships in human services is critical, as the context for all human services, both as a receiver and provider of services, is the relationships between the staff at all levels of the organization (Mohr and Bowen, 2009).

LifeShare is a provider of services to people affected by intellectual disabilities in several states. Their mission statement is *"LifeShare provides the highest quality of support services using innovate, person-centered approaches to guarantee individualized and holistic support, responsive to building meaningful relationships with the community and with individuals in the most compassionate and most cost effective manner."* (LifeShare, 2010) The organization is "100% restraint free and proud of it!"

The Bexar County Juvenile Detention Center in San Antonio, Texas teaches that the "relationships and respect" between the staff of the organization are the key to the security of the center. (Stanton, 2010). During the past 3 years, they have reduced the use of restraint over 50% in their secure juvenile probation unit. One of their staff trainers states "10 years ago the most valuable staff person was the one who could control the kids the fastest. Today, the most valuable staff are the ones who can talk kids down and never have to put hands on them. In fact, staff have a healthy competition with each other to see who can go the longest without using a hands-on technique to maintain safety." (Stanton, 2010)

In Calgary, Alberta, parents had refused to allow their child to attend a specialized school. After the school trained staff in a relationally based approach to addressing behavioural challenges, the parents said "This is the same building, but it is a different school." (Mann, S. Personal Communication 2008) Potomac Ridge Behavioral Health, a secure facility for adolescents affected by emotional, behavioural, and cognitive

disorders, provided training to all staff in the organization. As a result, there were significant reductions in the frequency and duration of restraint, with an 85% decrease in injuries to staff. (McBee, M. Personal Communication, 2007)

Even though these organizations have different legal underpinnings, different levels of physical security, and different goals for their services, the commonalities between them overcome their differences. Relationships are the most important of the factors to consider when assessing the potential to minimize the presence of violence and risk.

Trauma Informed Services

Without an understanding of the effect of trauma on human behaviour, relational interactions can re-traumatise individuals and lead to increases in workplace violence. The effect of trauma on the developing brain of children and the effects of childhood trauma into adulthood is well documented (Felitti et al, 1998; Perry, 2000, 2003; Mohr et al, 2000) Psychiatric hospitals around the world have made this the central element in the reduction and eventual elimination of seclusion and restraint The National Association of State Mental Health Program Directors (Jennings, 2004) use the term "trauma informed systems" to discuss the centrality of trauma to the work of recovery within the mental health system.

"Trauma-Informed Services - incorporates knowledge about trauma, prevalence, impact, and recovery in all aspects of service delivery. [It] Minimizes revictimization and leads to services that are hospitable and engaging to survivors." (Fallott, 2005) Services that are "hospitable" provide the emotional, psychological, and physical safety needed to recover from the traumatic experiences most people receiving psychiatric hospitalization have experienced. "Engaging" services invite participants to direct the process of their own recovery.

Leadership

Likewise, without continuous leadership focusing in the importance of workplace violence, old patterns of behaviour re-emerge and progress towards reducing workplace violence stops, and there may even be an increase in violent behaviour. The Dorothea Dix Psychiatric Center in Bangor, Maine, had focused on training, improved clinical skills, but it was not until leaders of the organization became involved on a daily basis that they saw restraint use reduced by 80%. (Colburn, L. Personal Communication, 2010)

The leadership of Charles Curie was central to the success of Pennsylvania's initial efforts to reduce the use of seclusion and restraint in that state's psychiatric hospitals. Jeffrey Chan, the Senior Practitioner for the Department of Human Services, state of Victoria in Australia has provided the leadership to implement the Disabilities Act of 2006, and subsequent reductions in the use of restrictive procedures.

In this paper there is not enough room to list all the leaders around the world who have taken on the responsibility of leading the way to increase workplace safety. Researchers, public officials, administrators, and most importantly direct support professionals have demonstrated that leadership is a role, not a title.

Benchmarking and Strategically Developed Goals

Many organizations use an approach to ensure and improve quality; the presence of strategically placed goals makes benchmarking easier and more meaningful to the stakeholders in an organization. Grafton, an organization serving children and adolescents in Virginia and several other US states, set a benchmark of reducing the use of restraint without increasing injuries to individuals served and/or staff. Using this approach, the reduction of restraint at the very least maintains safety. In the Grafton experience, restraint use decreased by over 90%, while injuries to staff reduced by 52% and the organization saved approximately $250,00 per year workers compensation costs due to injuries related to behavioural interactions. (Grafton, 2010)

Typical benchmarking includes reductions in injuries, restraint and seclusion, and associated costs. Other benchmarks could be perceived increases in safety, satisfaction with services, etc. It is important to discover ways to measure the presence of the positive, and not just the absence of a negative. While this data is "softer" it is helpful nonetheless.

Positive Behaviour Support

Positive Behaviour Support is the final common factor in this review.

Positive Behavior Support (PBS) is:

A. *An Understanding that people (even caregivers) do not control others, but seek to support others in their own behavior change process;*

B. *A Belief that there is a reason behind most difficult behavior, that people with difficult behavior should be treated with compassion and respect, and that they are entitled to lives of quality as well as effective services;*

C. *The Application of a large and growing body of knowledge about how to better understand people and make humane changes in their lives that can reduce the occurrence of difficult behavior; and*

D. *A Conviction to continually move away from coercion - the use of unpleasant events to manage behavior. (NAU, 2005)*

This definition places the use of behaviour change techniques in the context of support rather than control, and a belief that people who demonstrate behavioural challenges are entitled to a life of quality and effective services. It also emphasizes that the tools of behaviour change will be done by practitioners who are "continually moving away from coercion" (NAU, 2005). Valley Mental Health in Morgantown, West Virginia, serves approximately 1,000 people in a combination of in-patient, crisis, respite, day treatment, and out-patient programs. They focus a great deal on the use of Positive Behaviour Supports, even using a PBS approach to motivate and reinforce staff. From 2000-2009, a total of 2 restraints were done within the organization, and staff injuries from behavioural interactions are at or near zero every year. (Bellisario, M. Personal Communication, 2009)

Interaction Among Commonalities
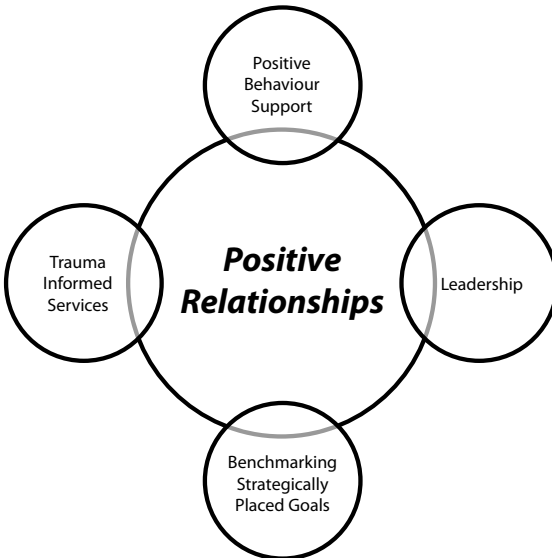
It is in the interactions between the above referenced elements that the impact of each element can be maximized. It is the foundation of positive relationships that increases the effectiveness of each of the factors. This holds true for organizations, and it holds true for families. Lisa Young is the mother of a young boy affected by multiple psychiatric and behavioural disorders. After receiving training in a relationally based approach she said:

"We encountered a challenge three months after implementing the relational, conceptual, and technical training. For the first time, I had to rely on my restraint training to see us through a very explosive episode. More importantly, I was unafraid! It was a short rage, lasting only 47 minutes. The hold was held for only 1 minute 32 seconds until he began to deescalate. He and I were both worn out at that point. Exhausted, he went to his room to rest. After a few minutes I checked on him. Although drowsy he sat up and really

looked into my eyes. He then said, "Wow mom, you handled me!" Then he hugged me and spoke for the first time the words, "I love you," while keeping eye contact.
On that day my life dramatically changed. My son felt safe and secure in the fact that I could handle him, even when he couldn't handle himself. Borrowing from MasterCard, "Having a child with behavioral issues, a challenge. Having training that empowers you with the knowledge to handle the behavior, priceless." That was 605 days ago. Since then we have lived as a typical family, able to eat at restaurants, attend church, see movies in a theater and even go to crowded public places like the zoo and amusement parks." (Young, L Personal Communication, 2008)

Conclusion

The goal of all workplace violence reduction and elimination efforts is to create the kinds of environments where people can live, learn, work and play with an increased feeling of safety. The centrality of relationships is demonstrated in the letter from Lisa Young, and the research of Herzberg and others. While there are many other tools such as sensory integration, speech pathology to increase communication, neuroregulatory interventions in the form of medication, etc., the commonalities listed were the most frequently reported. Further research on rank order may be helpful in designing new tools to achieve the goal of preventing workplace violence.

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Correspondence

Mr Bob Bowen
The Mandt System, Inc.
PO Box 831790
75083
Richardson
USA
+1 330 284 3191
bob.bowen@mandtsystem.com

Integrative Approach of Workplace Violence Prevention

Poster

Yun Sang Lee, Chun Kwok So, Kwok Keung, Andy Fok, Wai Kit Tang
Castle Peak Hospital, Tuen Mun, Hong Kong, China

Introduction

According to Hospital Authority (Hospital Authority, 2005) in Hong Kong, workplace violence is common in acute psychiatric ward. Numerous studies of workplace violence in healthcare settings indicated that acute psychiatric ward is the one vulnerable department around the world. Since 2006, under the concept of workplace violence prevention, a working group was formed in one acute admission unit (Ward E302) of Castle Peak Hospital in Hong Kong. The prevention program was devised and implemented to tackle the workplace violence issues. In 2008, the program structure was further enhanced on the treatment of patient and the training of staff. The program structure is continuously evolving.

Objectives

1. To prevent patient and staff injury and hardness due to violence.
2. To develop a harmony working atmosphere.
3. To build up a trust and respectful relationship between patient and staff.
4. To develop staff competence in management of workplace violence

Method

Workplace violence was one of the crucial reason resulting patients and staffs injury. The violent behaviours in mental patients were primarily due to the psychotic influence. Sometimes, it might relate to their insecurity feelings and tension about the mental hospital admission. Workplace violence prevention is a multifaceted approach (Beech & Bowyer, 2004; Smith-Pittman & McKoy, 1999). Based on the concept of workplace violence (Curbow, 2003), the elements to prevent workplace violence can be devised in four areas, clientele, staff, environment, and the system. They are interacted and dynamic in nature. All elements should be managed in well-balanced manner to subdue the occurrence of workplace violence.

Till now, the program could be divided into two phases. In phase one, from 2006-2008, this program aimed at establish the basis for achieving the objectives. On promoting the alertness of client and staff on workplace violence, the continuous environmental improvement works were carried out. Also periodical sharing session on workplace violence prevention had been conducted among the newly admitted clients. In phase two, from 2009 to now, factors on patient and staff were enhanced. The main focus was to develop the harmonious environment and a respectful relationship between client and staff. It is important to reduce the occurrence of workplace violence incidents.

Among numerous activities of the program, here are some of the highlights:
1. Ten Tips on Prevention: The Ten Tips on Prevention Slogans was developed to remind staff about the strategies and prevention of workplace violence.
2. Sharing on Better Customer Services: In sharing session on Better Customer Services, the speaker had integrated own experiences of patient, relative and staff and those selected Chinese philosophical principles to develop the content of the sharing. Through various sharing sessions, staff members were inspired on how to respond and manage the workplace violence, especially whilst facing the verbal assaults.
3. Drill on Management of Workplace Violence: Workplace violence drill is not common in different other units. In CPH, the first drill was launched in E302 in July 2009. Staff would have an opportunity to practice their learned skills and techniques in clinical environment, which empowered them to respond appropriately in real situation.

4. Integrated Referral System: Newly admitted patients would be invited to join the biweekly workplace violence prevention sharing session. After the assessment, based on the needs of individual, patient would be referred to corresponding psychosocial training groups, such as anger management group and family nursing, in wards. It ensured proper treatment was given to individual clients, and the ultimate goal of violence prevention could be achieved accordingly.

Results

In phase one of the program, incident of injury on duty (IOD) was declined, for instance, there is one staff injury and zero sick leave due to injury on duty. In view of the restraint rate, the percentage of patient being restrained was declined from 15% to 11%. The proportion on restraint due to aggressive behavior was reduced from 19% to 11%. In phase two, the IOD and restraint keep in low magnitude. After the phase two of the program, patient showed satisfaction on ward atmosphere and staff attitude through thanks card. Moreover, participating staff agreed that it promoted mutual respect and empathetic care in the ward. Staff experienced more safety at workplace and more confident to tackle conflict and workplace violence.

Recommendation

In coming future, the program will be implemented in the whole hospital. Hospital-wide workplace violence tackle program is planned and six core strategy work, including risk assessment, skill enhancement, training, environmental improvement, legal prosecution knowledge, and post-incident debriefing, would be carried out.

Conclusion

The elements on prevention of workplace violence are interacting. Considering all elements into one concept posed multiplied effect to reduce workplace violence. By adapting the workplace violence prevention measure based on concrete concept, there are significant improvement in reducing workplace injury and promoting effective treatment milieu. Alleviating the patient anxiety and alerting their legal responsibility help to control the violence due to intended aggression. Staff attitude training play a crucial role to develop the harmonious environment and a respectful relationship between client and staff. Management support to create a fair environment and equal communication culture nurture the interaction between staffs and patients.

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Correspondence

Mr Yun Sang Lee
E302
Castle Peak Hospital, Hospital Authority
15, Tsing Chung Chuen Road,
Tuen Mun, 00852 Hong Kong
China
+852 245 685 32
leeys2@ha.org.hk

Sociopolitical reasons of violence against healthcare workers and actual studies for public awareness

Poster

Pelin Demirci, Hasan Ogan, Zeynep Solakoglu
Turkish Doctors Union (The study group of Zero Tolerance Toward Violence), Istanbul Medical Chamber, Istanbul, Turkey

The country-wide process named 'The Health Transition Project' and the concurrent sociopolitical dynamics have rapidly disseminated violence against healthcare workers by indicating them as a target. The Turkish Doctors Union(TDU) started the organizational working process which aims "to perceive the ascending violence against doctors and other healthcare workers in medical environments including every dimension and to determine the procedures and measures that will be taken also to raise awareness among doctors and society"(2006).

In order to sustain a permanence to the campaign to carry out a comprehensive work and to help society apprehend healthcare workers such as nurses, hospital attendants and technicians, lawyers, judges, communication experts, patient rights representatives, sociologists and journalists are included into the working group aside doctor chambers(64),medical specialty associations(88). The group's structuring process starting with the workshop named "how to stop violence against doctors" established the sub-working groups (relating law, education, executive) and formed a communication network (siddetesifirtoleransgrup@googlegroups.com). Beside the workshop booklet publications, a website (www.ttb.org.tr/siddet) and partly 'Violence Lines' were put into practice.

The group started educational programmes to raise awareness and to gain competence for the struggle against violence. The materials for the first educational programme in October 2010 are about to be completed. In addition a booklet is planned to be published on behalf of TDU, which will be prepared in this process, 'How to deal with violence' in July 2010. The TDU had negotiations on legal precautions against violence with Ministry of Health however no concrete progress was achieved due to the inconsiderate and negative approaches.

In order to prevent violence in the health work environment we are also trying to build up a legal and democratic defence line by forming laws and regulations on 'Working conditions and security'. We had pourparlers with labour unions and associations and planned to organize a workshop throughout a campaign process in October-November 2010.

Correspondence

Mrs Pelin Demirci
Turkish Doctors Union
Istanbul Medical Chamber
Turkocagi Cad.No 17 Cagaloglu
34440
Istanbul
Turkey
+90 0212 514 02 92
pdemirci@gmail.com

Chapter 11 - Training and educational issues regarding clients and workers

An initiative to integrate services to victims of intimate partner violence (IPV) and HIV positive clients: Do Thai hospital staffs need any training?

Paper

Siriwan Grisurapong
Faculty of Social Sciences & Humanities, Mahidol U., Salaya, Nakhonpathom. Thailand

Abstract

After the 1st comprehensive service center for victims of IPV had been established in a Thai public hospital in 1999, this initiative has been expanded to most provincial hospitals throughout the country. The effort to integrate services to HIV & IPV to hospital services had been conducted in a pilot hospital in 2008 due to its interrelations. Having a satisfactorily result in working with these 2 vulnerable groups, the scaling up was planned. However, training to increase skill and change attitude of hospital staffs is an essential component. This project aimed to assess needs of these hospital staffs in order to scale up.

Method

Four provincial hospitals and 17 district hospitals in each region of Thailand which had established a comprehensive service for victims IPV had been determined as sites of study. Data were collected from 164 hospital staffs working with these 2 target groups by using self-administered questionnaires. An in-depth interview to key hospital staffs was also conducted to gain more details of their attitude. Data were collected between September and December 2009.

Results

Respondents mostly were in the age range of 31-50 years. Ninety percent of them were women and 78 % were nurses. Almost half of them working with HIV or IPV clients for 5-10 years and more than 90 % needed training. Only 40 percent of staffs had received training. The main barriers inhibited respondents from obtaining training were personal unavailability, no financial support and in a long line for quota to be trained. Issues which are highest needed were empowerment techniques, how to give general counseling to victims, important information that should be given and gender relationship & negotiating power for safe sex, respectively. For the training methods, they preferred study visit, lecture, having manual/protocol to read and having mentors from other hospitals to share experience and supervise. In average, they had been trained 0.66 time/year, and 0.77 time/year in attendance related meetings. The level of satisfaction in working with IPV or HIV is highly correlated with whet her being trained. These who are likely to be trained were only staffs working directly with these 2 target groups.

Learning outcomes

In order to provided services to victims of violence either as an isolated or integrated services, training to hospital staffs are truly needed, particularly, if the scaling up through out the country is planned. The components in the training should include not only clinical protocols but also gender & power relationship issues.

Correspondence

Ms Siriwan Grisurapong
Faculty of Social Sciences & Humanities, Mahidol U., Salaya
73170 Nakhonpathom
Thailand
+662 4419738
shsgs@mahidol.ac.th

Using Good old Leary in prevention of patient conflicts by using the 'Dutch' game 'beinvloedingsspel' (influence game) to influence people in a tactical way

Workshop

Fenno Moes
Durga Training & Advies, Haarlem, The Netherlands

Abstract

In the 1950's the American Psychologist Timothy Leary developed an interpersonal circumplex: a model representation of the different behavioural possibilities and their impact on others. Even today the model still contributes to gaining an insight in the effects of mutual communication. Based on the notion that one person's behaviour induces certain behaviour of the other, we can predict one another's behaviour, influence it and then make conscious choices about action and reaction. The prediction and influencing makes it a perfect model to use in (conflict) communication with patients.

As a trainer I use the model already 15 years in all my communication and aggression trainings. Instead of blaming the patient, client or customer for his behaviour and see it as something "static", the model gives the participant a tool to influence in the moment or choose for another approach to prevent certain behaviour in the future.

Leary's model, commonly known as Leary's Rose, because inspired by a compass rose, consists of two axes, which together form a cross. The vertical axis represents the measure of dominance while the horizontal axis represents the extent of "I-oriented" (task interest) and "we-oriented" (common interest). Bert van Dijk who wrote several books on Leary's Rose in Dutch and refers to the top of the dominance axis as "Above" behaviour and at the bottom of the axis, if behaviour is barely or not at all dominant, as "Below" behaviour.

An important outcome of Leary's research is that behaviour incites behaviour, sometimes equal or symmetrical and sometimes contrary or complementary behaviour. In his model Above incites Below and vice versa, and We-oriented incites We-oriented behaviour and I-oriented behaviour incites I-oriented behaviour. By making different combinations of Above, Below behaviour and We-oriented and I-oriented behaviour, the rose can be divided in eight segments: AW (Above-We-oriented) leading, WA; helping, WB; cooperating, BW; depending, BI; withdrawing, IB; defiant, IA; aggressive, AI; competing.

By knowing this and the fact, as already mentioned, that behaviour incites behaviour sometimes equal and sometimes contrary, you have the tools to influence or manipulate (non-desirable) behaviour of your patient (patients family members), client or customer.

To make the model available to a broader audience, Bert van Dijk and I developed in 2005 the "Het grote beinvloedingsspel" (The influencing game) and revised it in 2009. By playing the game, people learn as they go along, how to influence behaviour patterns.

Main activities in the workshop
In the workshop, I will give a short introduction on Leary's theory. After that the participants, will do a short test to find out, which behaviour has their preference. Then we will play the Game, with patient (or family members) carer situations/interactions, contributed by the participant.

Educational goals
The participants will have some news tools to effectively influence (possible) conflict situations.

Correspondence

Mr Fenno Moes
Durga Training & Advies
Postbus1139
2001 BC
Haarlem, Netherlands
+31 235 323 529. fenno.moes@gmail.com

Decreasing workplace violence via the implementation of the psychiatric nursing care model

Poster

R.J. Howerton Child
Cedars-Sinai Medical Center, Los Angeles, USA

Abstract

Emergency Department (ED) staff are often ill prepared to deal with patients who are experiencing acute exacerbations of a psychiatric illness which leads to not only sub-satisfactory care of this special patient population but also increases the possibility for patient centered violence against health care workers (HCWs). Approximately 40 percent of aggressive or violent incidents in the ED were attributable to patients with psychiatric diagnoses. The crowded, loud ED environment with decreased patient privacy, coupled with the lack of knowledge of ED Staff, add to the possibility of a psychiatric patient escalating to violence. This study was conducted in a Level I Emergency Department and Trauma Center that is located in Los Angeles, CA, USA with over 78,000 patient contacts per year. An evaluation of a massive educational project was implemented to improve the care of the psychiatric patient and ensure safety for the work environment by: 1). Decreasing the us e of inappropriate violent restraints, 2). Decreasing the number of verbal and physical staff assaults, 3). Maintaining zero elopements of patients on a psychiatric hold, 4). Implementing the Psychiatric Nursing Model of Care and 5). Decreasing the amount of time patients spend in violent restraints. The long term specific aims are to: 1). Improve the care of the psychiatric patient via patient satisfaction scores, 2). Improve staff satisfaction regarding the care of the psychiatric patient, 3). Maintain a safe work environment that is free from unavoidable patient assaults. The educational plan was implemented over a five week period and included lectures from psychiatric experts, role playing, case studies, power point presentation and viewing of psychiatric centered documentaries. A total of 407 staff members participated (out of 205 staff members, multiple members participated in more than one event). The preliminary data demonstrates promising statistics regarding decreased inappropriate violent restraint use, decreased staff assaults, and increased staff satisfaction. Preliminary data shows a decrease in restraint use from 15.6 violent restraints per month to 6 violent restraints per month. In addition to the specific aims, a tool was developed for the auditing the appropriateness of violent restraint use called the Violent Restraint Audit Tool (V-RAT) and could be applicable to other hospitals seeking to improve the quality of care provided to this special patient population.

Correspondence

Mrs R.J. Howerton Child
Cedars-Sinai Medical Center
8700 Bevelry Blvd
90048
Los Angeles
USA
+1 310 423 03 08
rjahy@ucla.edu

Violence and quality of life in the workplace: intervention program in nurses

Poster

Elizabete Borges, Teresa Rodrigues Ferreira
Oporto Nursing School, Porto, Portugal

Abstract

Background

Nurses' workplaces present evident changes at an organizational and individual level, as it is associated to high levels of stress (O'Brien-Pallas et al 2008) and to violent situations (Di Martino, 2008). This factors point out a reflex on the worker's quality of life, in their family, in the organizations and in society (Messeguer de Pedro et al, 2007).

Aim

This study aimed to describe the nurses' quality of life; to identify the relationship between psycho-social variables and quality of life scales; implement a psycho-educational program to help manage emotions, providing resources for managing stress related to the work of nurses.

Materials and method

It is an exploratory and descriptive type of study, integrated within the paradigm of quantitative research. It is also a prospective and longitudinal study, as it will make an intra-subjects approach, at two different points in time. The sample is made up of nurses / students of the Post-Graduation Course of the Porto Nursing School (N=151), who accepted to collaborate in the study. The instrument for collecting data was the Socio-demographic and professional form, and the Short-Form Health Survey (SF36). The Cronbach Alfa coefficient (SF36) was between 0.85 and 0.86. We implemented the intervention program, with a total of three sessions. The first sessions was about theoretical issues related to stress and violence, the second and the third ones integrated relaxation techniques for four muscular groups and the techniques of guide imagination.

Results

The results we would highlight that in a sample of 151 nurses 84.8% were female. The minimum age was 24 years and the maximum 54 years, and the average was 33.1 years (SD= 5.659). Regarding the professional category 36 (65.6 %) graduated. The nurses had 10.3 years working experience and 73,3% were the permanent staff of the institution. Regarding the main results acquired from the SF36, the scales which presented the high values were Physical Functioning (M=73.3; SD=26.6) and Bodily Pain (M= 70.2; SD=23.0) and the lowest one was General Health (M=50.2; SD=20.3). Through Student t we found significant statistically differences between scales and some of the psycho-social variables. The data shows association negative and low between violence and quality of life r (137) = -0.32, p<0.01.

Conclusion

We found that the quality of life is essential to the accomplishment of nurses. The results obtained corroborate the importance of the Training Services and Security, Hygiene and Health at Work, in the promotion of nurses' quality of life.

Correspondence

Mrs Elizabete Borges
Oporto Nursing School
Rua Dr. António Bernardino de Almeida
4200-072
Porto, Portugal
+351 225 073 500. elizabete@esenf.pt

Training staff in aggression management at Dimence. From risk awareness to useful tools in aggression management

Poster

Eric Stoppels, Carla de Bruyn
Dimence, Deventer, The Netherlands

Building a safe and risk aware organization: Training staff in aggression management

Introduction

There is a causal link between safety perception and dealing with aggressive incidents. The extent to which an employee feels adequately equipped to cope with the prevention and management of aggression would appear to favourably influence his or her safety perception. At Dimence, the course in aggression management and social security (ASV) forms part of the risk management programme. The programme's objective is 'to build a safe and risk aware Dimence'.

Course objectives

The training course was developed following studies into the attitude of nursing staff with regards to aggression and their perceived prevalence of aggression (Jansen, 2005, Jonker, 2007 and Scheffer, 2008, Dimence). The course is designed to assist in the prevention – or where necessary management – of aggression. The focus is on developing awareness of one's own actions and attitude towards aggression and on acquiring interactional skills.

Method

The theory that forms the basis of this course is divided into four key areas and is based on the vision put forward by Oud and Fleury (Connecting, 2007).

1. Vision on aggression in a carer-patient relationship
   Aggression is the result of interaction between two or more people in the context of a particular setting. An incident is never caused by just one single factor. There is always a complex interplay of individual factors, contextual factors and interactional factors.
2. Theoretical model
   The theoretical model adopted here is the attribution theory, which is based on the hypothesis that the meaning attributed by one person to the behaviour of another determines how they deal with that behaviour. Important concepts are implicit meta contract (that's how we do it), norm violation (does not meet expectations) and indignation. In practical terms, this translates as: what's happening? (develop awareness), what does this mean for me? (attribute meaning), what do I need? and what am I going to do?
3. Work definition of interactional skills
   Aggression is manifest behaviour that results from underlying emotions, feelings and thoughts. The manifest behaviour is the carer's access point to the patient's underlying emotions or thoughts. The carer's interactive and communicative skills are essential to achieving an understanding of the underlying causes of aggressive behaviour and to determining a suitable care programme. Entering into a dialogue on the underlying motives often undermines the function of aggressive behaviour.
4. Physical techniques
   Physical confrontations and interventions can damage the carer-patient relationship just as much as the use of force and pressure. This, however, is sometimes unavoidable. When training for physical interventions, course participants work as much as possible with techniques that do not injure or hurt the client. These techniques are generally effective. Pain stimuli are not used to exact a certain type of behaviour; this is strongly advised against on psychological and/or therapeutic grounds. The

administering of pain stimuli does not befit the carer-patient relationship. Where physical intervention is required, the safety of the client and the professional must be observed at all times. 'Caring for' is a key element in the approach and any intervention should be aimed at restoring contact with the patient as quickly as possible before, during or after the incident. The importance of being sensitive to, and aware of, the need to maintain a professional, therapeutic working relationship cannot be emphasized enough.

In practice

At the end of the course, employees will be able to directly apply the acquired knowledge and skills to their daily work. Much use is made of experiential learning as this has proven to produce the best results. Contextual factors play an important role in the interaction with the patient, and staff job profiles and tasks can vary. For this reason, a wide range of courses has been developed for each discipline or department, where a distinction is made between employees' levels, knowledge and skills. The courses are carefully developed to meet the learning needs of the target group and the course material is designed to be readily identifiable to the course participants. For example, there is a basic course for beginning professionals, one for experienced professionals, and courses tailored to different disciplines (doctors, nurses, activity supervisors and therapists, secretaries, etc.). In some cases, the preference is for a course for the whole multidisciplinary team. Sometimes the only way to coordinate a uniform approach on, say, reducing force and pressure is in a multidisciplinary setting.

Personal safety consultant

Dimence has decided to hire its own safety consultants. This has a number of advantages, the safety consultant:
• Knows the organization, knows the institution's culture and speaks the same language;
• Is directly involved with relevant processes regarding the area of safety, liaises between project groups, management and workers on the workplace and provides support from a user's perspective;
• Has experience with the primary process, can anticipate staff needs by virtue of being actively on site, and can assess whether the training in aggression management is effective in practice and/or point out what else is needed;
• Can assist in implementing changes on the shop floor by providing information and representing the interests of workers.
• Will cost 40% less than the hiring of external trainers.

The safety consultant will be assigned a number of tasks within the organization:
• Developing, supporting and implementing social security policy;
• Providing consultation and advice with regards to social security;
• Training staff;
• Coaching staff.

Results

The results of the evaluations completed by the course participants on the ASV social security training course show that the range of courses met the practical needs of the profession. The participants greatly valued the trainers' experience with the workplace. An average 86% of the participants felt that they dealt with aggression in a different way after having followed the course and 74% noted that their opinion about aggression had changed. The course participants also felt that they would be more self-aware and confident when faced with an aggressive situation in the future. The insights provided on the prevention of aggression and the team techniques developed were also greatly valued. The average score given by the course participants was an 8.3.

Correspondence

Mr Eric Stoppels
Dimence
Nico Bolkensteinlaan 1
7400 GC
Deventer
The Netherlands
+31 570 639 600
e.stoppels@wanadoo.nl

Explaining, Reflecting and Managing Aggression and Violence in Health Care using the NOW-Model

Workshop and poster

Johannes Nau, Nico Oud, Gernot Walter
Protestant Centre of Nursing Education, Stuttgart, Germany

Introduction

Theories and models are made for guiding people in their daily life and practice. They are designed in order to describe and explain phenomena and to allow accurate prediction what to do. If possible they should fulfil criteria like clearness, straightforwardness, profoundness, universality and accuracy.

In the field of aggression and violence many theories and models of violence are available. Bjørkly found up to 140 works on theories of aggression [1]. Many models or theories provide valuable information. They provide statements, concept clarification and enable researchers to discuss aggression and violence related factors in many ways. However, the question may arise which theory and model is the most appropriate in the field of healthcare or, more exactly, which theories fit together in a meaningful way.

Examination of these theories and models may lead to the conclusion that they often focus on a particular detail of aggressive episodes. For example, some theoretical approaches refer to the individual arising of aggressive behaviour by the so called perpetrator triggered by aversive stimulation [2]. Others refer to educational issues [3] or ward culture and atmosphere [4].

During the last decade, thoughtful attempts were made in order to provide more comprehensiveness and develop more general models, for example the general aggression model[5] and the model of inpatient aggression [6]. However, those models are either designed for use in a specific setting or they are not putting interactional aspects into focus. That's why Whittington and Richter argued that the missing link in health settings is the idea of interaction [7]: From individual to interpersonal. We would like to emphasize that this kind of interaction is taking place in a specific context or environment. We were in need for models to guide us and allow us to find appropriate comprehensive interventions for the prevention, management and aftercare of aggressive episodes in healthcare. Especially young colleagues entering the ongoing discussion about the management of aggression report difficulties getting started and they talk about difficulties to value the existing models, their relevance and use in practice. Thus we concluded, that for didactical reasons as well for scientific reasons and last but not least for practical reasons an integrative practice model should be developed as a sort of an umbrella model for explaining, reflecting and managing aggression and violence in health care.

Methods

Inspired by the PATH-Model [8], which starts from formulating a Problem definition, going over to Assess the problem by finding explanations for the problem, continuing to develop and test a Theory-thereby, integrating a process model and merging into the development of Help, the authors carved out a model similar to the one presented here. Using several case vignettes in different settings they tested the new model and made several further improvements till it seemed matured enough to be universal and accurate and at the same time clear and simple.

Results

Help for the prevention and management of aggression is possible when aggressive episodes in healthcare are seen as a multifactorial phenomenon concerning emergence, occurrence and problem solving. A model should take into account personal factors of patient/visitor and staff, environmental factors and the interactional course between staff, clients, environment as well as organizational issues. Aggressive

behaviour should be seen as an attempt to communicate. One should keep in mind that aggressiveness may have objective clues but also should be seen as a result of attributional processes within the observer as well as within and between the participating persons. Instantly it became obvious that a dichotomy of perpetrator and victim is neither helpful nor purposeful for finding sustainable solutions for the management of aggression in this context. A useful model has to surmount this dichotomy. In addition a model should not only focus on issues promoting aggression but also on deescalating resources and their preventive potential. By this the sense of security and the equilibrium of all persons involved could be promoted, maintained and/or reinstated. The model should emphasise the whole of the situational aspects and should not exclude precursors of an episode and consequences at the end of the course of events.

In addition the authors were in favour of a model which enables instant clues and insights into how to interpret situations and derive ideas about possible interventions to handle the situation and how to shape the management of aggression and violence in general.
Finally a visual model was derived as printed in Box 1.

Box 1: The NOW model
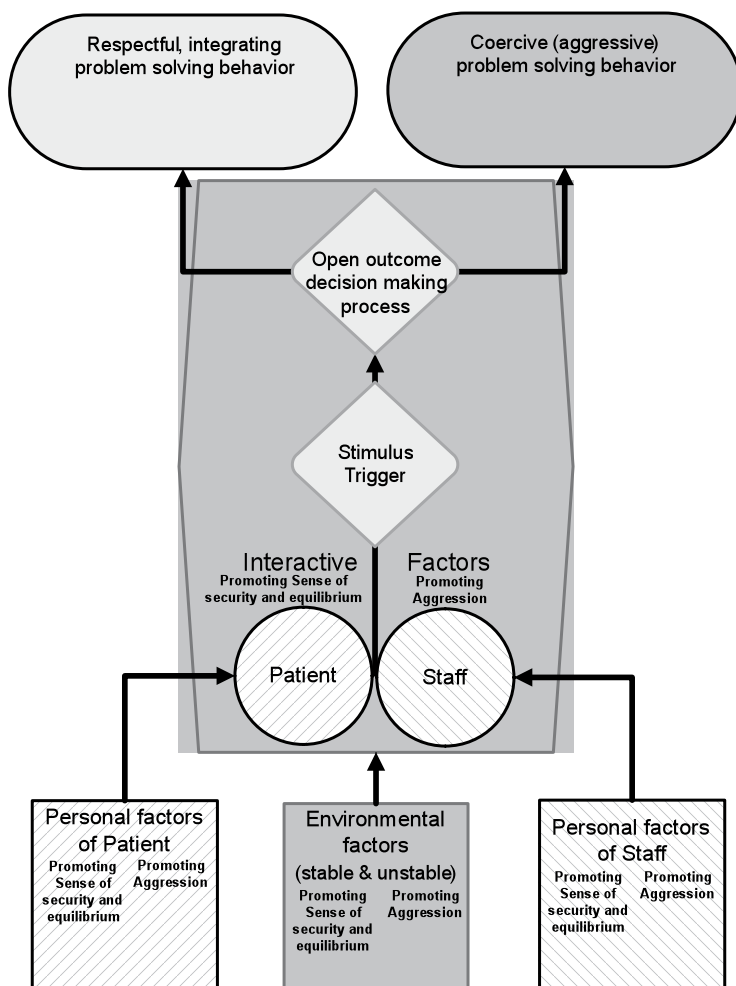
NOW Model (Nau, Oud & Walter)
An integrative, interactionist situational modell to explain and describe the onset and course of aggressive encounters in health

The model in its current state provides a theory integrating overview of the process from 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. From the process model a scheme could be derived which fosters thinking about essential elements of the occurrence of aggressive episodes (Table 1). The model got he name "NOW-Model" because of its emphasis of the process at the present time. (It is only a nice coincidence that the name of the model represents at the same time the initials of the authors)

Table 1: Check-Scheme to determine influencing factors

	Promoting Sense of security and equilibrium	Promoting aggression
Personal factors of patient		
Personal factors of staff		
Environmental factors (stable and variable)		
Interactive factors		
Examples of Triggers		

References for the NOW model:
Personal factors (patient, staff) Physiological/biological factors [9, 10]; Genetic determinants [11]; Pathologic factors, diseases, intoxication [12, 13]; Medical factors: [14]
Personal attitude towards aggression [15, 16]; Personally traits, skills and resources [5, 17, 18]; Developmental factors [3, 19]; Role expectation / Expectations concerning expectations [20, 21]; Influence of psychoactive substances [22]
Environmental factors: Managerial, edificial circumstances, team atmosphere [4, 6, 7, 23-26]; Behaviour depending on scripts and setting [27]
Interaction: Communication [7, 28-31]; Social interactionist approach [32]; Expectations concerning expectations [20]
Triggering factors: Four elements of messages [28]; Perceived injustice [32, 33]; Attribution und emotion [34-36]; Aversive stimuli [2, 37]
Decision making: Perceived intention, emotion and beliefs of others [38, 39]; Influence of mood [36]; Goal expectation [40]; Self-efficacy [41-44]; Inhibition of aggressive response [45]
Problem solving behaviour (respectful, coercive…): Script theory [27]; Learning processes [3]; Coercive behaviour [32, 46]; Meaning of interaction [7]; Assault cycle and related interventions [35, 47]; Conflict Solutions: Flight – Fight – WIN-WIN [35]; Criteria of de-escalating performance [48]; Creative problem solving, Transcend method [49, 50].

Discussion

Some limitations of the model have to be addressed. First of all, the model is not designed to deal with criminal aggression like robbery. It deliberately focuses on reactive aggression which is, because of its complexity, difficult enough to be visualised in a diagram.
However, even if the restriction on reactive aggression would be accepted, the diagram may be perceived as old wine in new wineskins. Critics could state, that none of the elements is new. Yes, they are right. However this includes the benefit that older theories are better tested. Often they are evidence-based and well referenced. However, even in that case one should remain careful because even evidence-based theories may fail, as we know. Sometimes, depending on their research design, they include oversimplification, may fail external validity or may provide contradictory evidence [8].

A further point of discussion has to be whether or not it is adequate putting together (a range of) selected theories. Of course eclecticism, in its meaning of selecting applicable statements of a theory and ignoring important other elements at the same time, is seldom fruitful because theories are to be seen as a whole. However, the NOW-Model composed not elements of theories but putted all those theories together which are able to provide description, explanation and prediction. Probably there are theories which should have been considered to be included in the NOW-Model but we didn't recognize this or we were not acquainted with them. We hope, that future research will provide more insight and may be able to identify false theories and construct better theories and thus will allow improving the model. All in all we do not know whether the model is true; however at the moment we feel, the NOW-model is at least viable.

Objective of the workshop:

In this workshop the NOW-Model is presented. The presenters invite to discuss resources and flaws of the model in order to test its usefulness and to get hints for further improvement. Participants will have the opportunity to use the model and apply it to their own work place settings.

Methods within the workshop:

Presentation, group discussion, work groups, summarising plenary discussion

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Correspondence

Mr Johannes Nau
Protestant Centre of Nursing Education
Stoeckachstr. 48
70190
Stuttgart
Germany
+49711997992402
j.nau@gmx.de

Standardizing violence prevention training: A collaborative approach to developing a provincial curriculum

Paper

Andrea Lam, Chris Back, Dailaan Shaffer, Catherine Trask
Occupational Health and Safety Agency for Healthcare in British Columbia, Vancouver, Canada

Introduction

Violence in healthcare is prevalent in the Canadian province of British Columbia (BC). In 2007, over 925 BC healthcare workers lost time from work as the result of injuries caused by violent acts, which is approximately 12% of the time-loss claims from the healthcare sector [1]. Violence prevention training has been suggested as an intervention, yet violence prevention training practices vary across BC healthcare sectors and organizations. Commercially available violence prevention training programs exist; however, they are often not designed specifically for healthcare settings and can be expensive and inflexible due to certification requirements. Some organizations have developed healthcare-specific training courses, but there is a lack of consistency across the province. These challenges result in an inefficient and costly use of limited resources.

To address the issue of violence in healthcare, a provincial committee was formed with a mandate to develop and oversee the implementation of a comprehensive provincial violence prevention strategy for all healthcare worksites. Given the challenges to providing consistent violence prevention training to healthcare workers throughout BC, the provincial committee assembled a Curriculum Team of violence prevention experts from BC's Healthcare Unions, regional Health Authority employers, WorkSafeBC, and the Occupational Health and Safety Agency for Healthcare (OHSAH) in BC to develop a provincially recognized, recommended, healthcare-specific violence prevention training curriculum.

Methods

The development of the Provincial Violence Prevention Training Curriculum began in August 2009 and continued with monthly meetings. The Curriculum Team first conducted a needs assessment to identify and prioritize the violence prevention curriculum topics that would apply to the majority of healthcare workers. Subsequently, the Curriculum Team: developed high-level learning objectives; identified which workers should receive which level of training; and determined the high-level course content and format. It was determined that most of the core violence prevention training curriculum should be developed in a modular online format, with hands-on training for advanced violence prevention topics to be addressed through the subsequent development of classroom modules.

Online module development was carried out by Instructional Designers under the direction of the Curriculum Team. Once complete, each online module was reviewed by an external user feedback group of 6 to 10 healthcare workers representing target health sectors and occupations. Feedback from the group was gathered via structured interview questions, summarized into a proposal with suggested changes, and approved by the Curriculum Team.

The final step in the module development process was an internal and external review of the online module content. The Curriculum Team completed the internal review process by reviewing the online module content to determine whether the online curriculum met the objectives set out in the curriculum project terms of reference, and identify where the content had inaccuracies, omissions, or inconsistencies (i.e., terminology, language). Four external reviewers, who had violence prevention expertise in a variety of care settings, also reviewed the online module content for accuracy, completeness and consistency. Once the internal and external reviews were complete, the comments and feedback were compiled, vetted by the Curriculum Team and incorporated into the online modules.

Results

The Provincial Violence Prevention Training Curriculum online modules provide a comprehensive overview of key violence prevention topics applicable to all healthcare workers (i.e., clinical staff, administrative staff, maintenance staff, etc.). A summary of the content for each module is described below:

- **Module 1: Overview** - Introduces violence in the workplace, the impact it has on healthcare workers, and employer and worker responsibilities with respect to violence prevention.

- **Module 2: Recognizing and Responding to Risk** - Introduces how to identify risk factors and stressors for violence, how to respond appropriately to emotional distress, verbal and physical violence, and how to recognize and respond to signs of tension reduction.

- **Module 3: Interventions in Acute/Residential/Community Care** - Builds on Module 2 by informing learners about how to identify and choose strategies to minimize or eliminate patient/resident/client and environmental risk factors, and identify ways of interacting with others that may decrease their stress. Module 3 is available in three different versions that target specific healthcare sectors: acute, community, and residential care.

- **Module 4: Communication Basics** – Informs learners about the benefits of becoming better communicators, and the importance of non-verbal communication. Learners are also informed about how to recognize the effect of their own body language on others, and how a person's body language may give advance warning of an angry or violent reaction.

- **Module 5: De-escalation** – Informs learners about de-escalation and when to use and not use de-escalation techniques.

- **Module 6: Responding to Physical Violence** – Informs learners about preventive strategies for self-protection from physical violence, how to recognize cues that a person's behaviour may be escalating, and what to do if they experience or witness a violent incident. Learners are also introduced to formal and informal team responses.

- **Module 7: Post-Incident Response** – Informs learners about worker and manager responsibilities following an incident, the importance of documentation, what post-incident support is available and how to access it.

- **Module 8: Behavioural Care Planning for Violence Prevention** - Informs direct care workers about how, when and why to conduct a patient violence risk assessment, and the ways in which identified risks for violence can be communicated. Learners are also introduced to strategies for developing interventions for behaviours that require caution and those that indicate high risk, and the role and importance of accurate charting.

For individuals without access to a web-based source for the online modules (i.e., via the internet from an external server or the intranet from an internal server), CD-ROM versions of the online modules were created. Paper-based self-study guides were also developed for individuals who do not have access to a computer.

In June 2010, the eight core online violence prevention modules were showcased at a dissemination forum for violence prevention stakeholders from each region throughout the province. Participants previewed the online modules containing interactive media with flash animation, videos and quizzes (Figures 1 and 2). The final versions of the online modules and self-study guides were then distributed to each regional Health Authority to implement. The modules were also incorporated into OHSAH's Learning Management System, which is available through OHSAH's website, to allow healthcare organizations who are not directly operated by a Health Authority access to the Provincial Violence Prevention Training Curriculum.

Figure 1: Screen shot of online module content from the Provincial Violence Prevention Training Curriculum online Module 1: Overview.

Figure 2: Screen shot of a drag and drop quiz from the Provincial Violence Prevention Training Curriculum online Module 1: Overview.

Discussion

The Provincial Violence Prevention Training Curriculum development process followed by the Curriculum Team was successful in creating a series of provincially recognized online training modules that provide an overview of the key violence prevention concepts and skills that apply to all healthcare workers. Feedback from frontline healthcare workers provided validation and valuable information that was used to improve the content, format and usability of the online modules. In addition, the internal and external review process provided the Curriculum Team the opportunity to identify and correct any gaps, inaccuracies, or inconsistencies in content. The online, CD-ROM and self-study guide formats provide a flexible method for disseminating the curriculum, allowing for rapid, standardized delivery, even in geographically remote locations.

During the curriculum development process, the Curriculum Team encountered several challenges including the heavy workload and limited availability of Curriculum Team members, and a compressed project timeline. Key aspects of the joint collaborative process that overcame such challenges were:

- Stakeholder buy-in, time and resource commitment
  - The Provincial Violence Prevention Training Curriculum Project had the commitment of the BC healthcare stakeholders on the Provincial Violence Prevention Steering Committee (PVPSC). Each of the Curriculum Team members were selected by members of the PVPSC and supported by their respective organizations to develop the curriculum. The dedication of each Curriculum Team member was exceptional; the majority of the Curriculum Team attended monthly 3-day meetings and completed work for the project between meetings in addition to their regular workload.
- Funding
  - External funding from the Joint Quality Worklife Committee and OHSAH dedicated to the creation of the Provincial Violence Prevention Training Curriculum was essential to providing the financial support for the Curriculum Team members to develop the curriculum (i.e., cover travel and meeting expenses; fund administrative support), and to acquire the instructional design and graphic design expertise needed to create the online modules.
- Instructional and graphic design support
  - The Provincial Violence Prevention Training Curriculum was developed with the guidance of Instructional Designers. The Instructions Designers helped the Curriculum Team follow the ADDIE model when developing the curriculum; this ensured that the curriculum was developed in a structured, systematic way. The ADDIE model is an instructional system design process that includes the steps Analysis, Design, Development, Implementation, and Evaluation [2]. In addition, the Instructional Designers had technical knowledge and experience developing online modules, as well as graphic design support which was vital to the development of the online modules.
- Project support by OHSAH
  - OHSAH is a provincial occupational health and safety agency for the healthcare sector. OHSAH's goal is to reduce workplace injuries and illness in healthcare workers and return injured workers back to the job quickly and safely. OHSAH is jointly governed by employers and unions (bipartite), providing an innovative approach to improving workplace health and safety in the healthcare sector.
  - OHSAH provided project coordination and administrative support to the Curriculum Team throughout the duration of the curriculum development process. Given the time constraints of each Curriculum Team member, OHSAH's support enabled the Curriculum Team to focus on content development. OHSAH's bipartite position on the Curriculum Team also helped to facilitate meeting discussions and assist the Curriculum Team to reach a consensus on issues that were politically sensitive.

Determining the logistics for various aspects (i.e., technological, financial) of the provincial implementation of the online modules was recognized early on in the curriculum development process as critical to the long term success and sustainability of the Provincial Violence Prevention Training Curriculum. It was agreed by the Curriculum Team that the implementation process would be carried out at the regional level by each Health Authority with the guidance of existing bipartite Regional Violence Prevention Committees (RVPCs). This agreement allows each Health Authority the flexibility to implement the curriculum in keeping with their organizational priorities and available technological resources. To assist each RVPC with the regional implementation of the online modules, the Curriculum Team developed recommendations for a variety of implementation considerations that each region needs to assess and make decisions about before launching the online modules including: how to obtain organizational buy-in; how to meet technical infrastructure requirements; how to obtain financial and management support; and which communication/promotion strategies to use.

The need for hands-on training for advanced violence prevention topics (e.g., de-escalation skills and strategies for physical violence) has been acknowledged by the Curriculum Team; development of four core classroom modules for the Provincial Violence Prevention Training Curriculum began in April 2010 and is expected to be complete by March 2011.

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Correspondence

Mrs Andrea Lam
Occupational Health and Safety Agency for Healthcare in British Columbia
Suite 301 - 1195 West Broadway
V6H 3X5
Vancouver
Canada
+1 778 328 8086
andreal@ohsah.bc.ca

Walking with Moreno: How concepts and techniques from psychodrama and role training can help us be creative in managing aggression in the workplace

Workshop

Wendy McIntosh
Davaar Consultancy, Brisbane, Australia

Moreno is credited as being the founder of psychodrama, sociodrama, group psychotherapy and role theory. Moreno trained as a psychiatrist in Vienna in the 1920's. He moved to America in the 1930s and opened his own hospital in Beacon Hill outside New York. Moreno had an idea that every person was a creative genius. He believed that everyone had the potential to be spontaneous and creative when faced with new situations.

Understanding the roles that self and the other interact from was essential to Moreno's work. He described three main ways of relating: moving against, moving towards and moving away from. In moving towards there is a complimentary relating between people. Moving against and moving away from are positions more likely to create tensions and thus aggressive and or conflicted relationships.

This workshop will introduce participants to major concepts and techniques from psychodrama including role reversal, mirroring, doubling and role training. Participants will have the opportunity to understand the role of aggressive and threatening behaviours from others (clients and or colleagues) and their own reactions and responses to same.

Correspondence

Mrs Wendy McIntosh
Davaar Consultancy Training & Development
PO Box 322, Wellers Hill
4121
Brisbane
Australia
+61 411 385 573
whmcintosh@bigpond.com

Teaching prevention and early intervention with potentially violent individuals and groups

Paper

Linda O'Dell, Wanda Shull
Veterans Health Care System of the Ozarks, Fayetteville, AR, United States of America

Health care has become an increasingly violent setting for staff and patients. Teaching staff how to avoid potentially dangerous situations is a challenge for everyone. Whether the place of employment is in a city, in a rural setting, in a hospital setting, or in a community setting it is important for health care workers to be able to apply general knowledge and principles to specific situations. This may be accomplished through classes that demonstrate and practice techniques to manage a patient who is losing (or has lost control) of behavior, formal class settings, and informal discussions and applications of principles to situations. This presentation will discuss styles of learning and methods that can be utilized to enhance learning of adults.

Correspondence

Mrs Linda O'Dell
Veterans Health Care System of the Ozarks
1100 North College Avenue
72703
Fayetteville, AR
United States of America
+1 479 443 4301
BeauGarreth@ymail.com

Prevention and management of violence and aggression training in dementia: Turning the tide

Paper

Barbara Vincent, Keith Hayns, Jane Shepherd
Sussex Partnership NHS Foundation Trust, Worthing, England

Introduction

Training in the Prevention and management of violence and aggression (PMVA) in mental health services, especially the use of physical interventions, has traditionally not been deemed appropriate for use in older people's mental health services. The threat of physical assault is, however a real issue for staff particularly those working with people with dementia. Nurses are often required to work with challenging situations without the necessary knowledge and skills to do so confidently and safely. The National Audit of Violence Final Report published by the Royal College of Psychiatrist's research unit on behalf of the Healthcare commission raised the issue of training for the first time in older people's mental health units in 2007. It found that 73% of staff working on units for people over 65 with organic disorders such as dementia had been assaulted as compared to 46% of nurses working on units for adults of working age (RCP Research Unit, 2008). Challenging behaviour is increasing on in-patient dementia care units as older people are maintained in the community longer and are physically fitter than twenty years ago. Yet there appears to be a general reluctance to consider PMVA training in older people's services and in particular in the care of people with dementia. The National Audit of Violence, 2007 covered 203 in-patient units from a mixture of mental health and learning disability wards including nineteen units for older people. Staff working on older people's units reported only 67% had attended some training in the prevention and management of aggression and violence in the last 5 years and of those 50% were dissatisfied with the training. Access to training relating to the prevention and management of violence in older people's services was reported as variable and where training was available; many staff reported that it was not tailored to the very particular and varying needs of older people. The conclusion drawn was that many staff and consequently patients were being exposed to an unreasonable level of risk. The audit recommended that training should be tailored to the needs of older people's services and in particular those needs associated with dementia, challenging behaviour, and physical frailty (RCP Research Unit, 2008).

This paper presents an evaluation of a training programme for in patient nursing staff tailored to the needs of older people and in particular the needs of people with dementia. The training was piloted in four inpatient units, two for organic mental health needs and two for people with functional illness over a period of six months. The pilot was evaluated through pre and post questionnaires based on the National audit of violence, 2008 (RCP Research Unit, 2008). 96% of staff reported they had been attacked, threatened or made to feel unsafe prior to the training compared with 52% post training. There was also a sharp reduction in reported violent incidents from 65 violent incidents reported in the 6 months preceding training to 10 incidents in the 5 months post training. The training enables nursing staff to provide patients and families with a safe environment by having the skills to manage high levels aggression therapeutically. In addition nursing staff working in inpatient services for dementia feel supported and valued in having their expertise in managing behaviour that challenges in people with dementia recognised, while acknowledging the high levels of aggression they face.

Whilst aggression and violence are an increasing part of everyday care in working with people with dementia, there continues to be a reluctance to develop such training in older people's mental health services. National guidance has since supported the use of the use of physical interventions with older people and people with dementia in both health and social care settings (CSCI, 2007.NICE/SCIE, 2007. RCN, 2004.). NICE guidance on 'Dementia', 2007 states "the role of the inpatient unit is to provide a safe environment, staffed by clinicians who are trained in the care of people with dementia, the assessment and management of those with behaviour that challenges and the management of aggression" and yet the National Audit of Violence, 2007 published in the same year demonstrated that training in a prevention and management of aggression and violence had not been happening consistently in older people's mental health services, and training incorporating older people's mental health specific issues even less (RCP, 2008).

Why is this so? Firstly there seems to be reluctance to acknowledge that older people can be violent and a belief that violence and aggression are somehow manifested differently in people with dementia. This may be from ideas such as old people are not capable of being aggressive or violent or that managing violence using techniques associated with Control and Restraint may be seen as detrimental and unsafe with people who are frail. In the very often distressing world of dementia a person is very likely to experience the fear, frustration and misunderstandings that can lead to aggressive and violent behaviour. Physical and verbal aggression are amongst the most common behaviours seen in people with dementia and those which patients and carers find the most distressing, often resulting in a person with dementia either being hospitalised or institutionalised, (Gormley et al, 2001). The literature also shows that older men with dementia in particular are at a very high risk of developing delirium. Delirium, also known as an acute confusional state leads to a person experiencing acute confusion, disorientation and impaired consciousness and can often result in extreme aggressive and disturbed behaviour which is difficult to manage, (Burns et al, 2004, NICE/ SCIE p70, 2007). As a result medication is being used more often than not as the treatment of choice in the management of challenging behavior in people with dementia. However recent research has raised concerns around the harmful effects of over prescribing of antipsychotic drugs to people with dementia (All-Party Parliamentary Group On Dementia, April 2008). There is therefore a need to find non pharmacological approaches to managing people.

Secondly there is a negative view held about the use of PMVA techniques generally and in particular the view that such training is purely about physical restraint. PMVA trainers have historically been taken in the main from forensic services where PMVA was first adopted in mental health services. This has led to the position that PMVA training belongs to forensic and working age services and not those of older people's mental health and certainly not dementia services. There also appears to be a view that care staff working with people with dementia in distress are not as likely to need to use prevention and management of aggression and violence techniques and this is seen in fact as a failure of good dementia care. This implication puts enormous burden on care staff working in inpatient services for people with dementia in an environment in which it is acknowledged the primary reason for someone being admitted is because of violent behaviour. As Gwyn Grout, a Nurse Consultant in Older People's Mental Health services said "Staff need to know how best to respond when their person centred, de-escalation skills have been thwarted" (Donaldson, 1998, Grout, p16, 2008 NICE/SCIE, 2007).

Course Content

The course design team consisted of the author as Practice Development lead and Lead Nurse in Older People's Mental Health services, the Consultant Psychologist working in the Practice Development team and the organisation's PMVA lead tutor. The development of the five day course provided a real opportunity to capitalise on the wealth of knowledge and experience around dementia care and managing behaviour that challenges and marry it to that which underpins prevention and management of aggression and violence training in mainstream mental health practice. Understandings of aggressive and violent behaviour in dementia were explored as unexpressed need drawing on best practice in person centred dementia care. A reflective practice element was also incorporated into the training which worked well in helping staff understand challenging behaviour in the context of the person with dementia's social circumstances and biography (NICE/ SCIE). The course was also designed in line with the national syllabus which addressed specific vulnerable groups such as older people (NIHME 2005). The author was able to draw on her own years of experience as a Nurse and Ward Manager of Older People's Mental Health inpatient units. Additionally the author trained as a PMVA tutor which greatly increased her credibility in providing training suitable for older people's mental health services. However in order to make decisions about the content of the physical intervention the author was greatly indebted to the PMVA Lead for the Trust, who appreciated both the needs of the client and the sensitivities around prevention and management of aggression and violence training with this client group. He was able to offer very creative adaptations to the physical interventions as part of the training to be delivered. Taking all the above into account a pilot week of training was launched in September 2008 for senior nursing Staff within In-Patient Services.

Evaluation

This training project was initially rolled out as a pilot across four inpatient units, two for people with organic mental health needs and two for people with functional illness over a period of six months. In total 68 staff were trained in PMVA between December 2008 and March 2009. This represents 74% of staff working on those inpatient units. The pilot was evaluated through pre and post questionnaires based on the National audit of violence, 2008. 68 questionnaires were sent out; 52 were returned pre course and 23 were returned post course. 96% of staff reported they had been attacked, threatened or made to feel unsafe prior to the training compared with 52% post training. However 75% staff felt they dealt well with violence from service users pre-training this rose to only 78% post training. There were 65 violent incidents reported in

the 6 months preceding training (39 service user assaults on staff, 16 between service users), as against 10 incidents in the 5 months post training (7 assaults on staff, 3 between service users).

Conclusion

By combining the knowledge underpinning PMVA training and older people's mental health expertise, the author has put together an Older People's Mental Health specific course in line with national guidance. This training is now part of the organisation's overall training programme and is managed by the Lead Tutor for PMVA Training programmes. Forensic and working age mental health services have historically focused on physical interventions rather than the psychological and preventative aspects of managing violence and aggression, something they have been much criticised for, (SNMAC, 1999). In contrast nurses working in older people's mental health inpatient services have had to be creative in managing violence and aggression in the absence of having training in physical interventions. Nurses reported feeling valued and supported because this training acknowledges the high levels of aggression and violence they have had to face. The current evaluation did not capture this but the training has been adapted over the period it has been delivered to incorporate practitioners experiences and knowledge. Anecdotally nursing staff have reported increasing confidence in their skills in verbally defusing situations because of their increased confidence in their own ability and their knowledge of physical interventions. The author intends to research this as her dissertation for the Msc. in Clinical Studies and Education.

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Correspondence

Mrs Barbara Vincent
Sussex Partnership NHS Foundation Trust
Swandean, Arundel Road,
BN13 3EP
Worthing,
England
+44 1903 843000
barbara.vincent@sussexpartnership.nhs.uk

The Training Implementation & Evaluation (TIE) Study: An investigation of a 'Process' based approach in providing training in the safe effective management of work related aggression and violence within health and social care

Paper

Kevin McKenna, Seamus Cowman, Moira Maguire
Dundalk Institute of Technology, Dundalk, Ireland

Abstract

Background and context

Aggression and violence encountered within clinical settings is a complex issue which can diminish the quality of working life for staff, compromise organizational effectiveness and ultimately impact negatively on the provision of care services (McKenna 2008). Notwithstanding the now well acknowledged recognition that effective responses include multi-faceted organizational approaches, one critical component of any response is the provision of safe effective training to staff in the management of aggression and violence. Concerns have been expressed however regarding the structure, content and effectiveness of such training which has prompted a critical re-appraisal of 'off the shelf' and 'one size fits all' approaches in favour of organizationally informed 'process' based training.

The Study

This paper will describe the an innovative programme which prepares staff from multiple disciplines as instructors who are competent to design and provide customized training which is needs assessed, service specific, fit for purpose, and responsive to the various manifestations of aggression and violence encountered within diverse clinical settings. The implementation of this programme was paralleled with a systematic investigation of the impact and effectiveness of the training provided. The study investigated the effectiveness of this 'process' approach in providing training. The study involved 300 staff from seven diverse services including: Ambulance, Accident & Emergency, Childcare, General Hospital, Intellectual Disability, Older Persons, and Psychiatry, and employed a quasi-experimental design of pre, post, and re-test measures utilizing two stands.

The first strand utilised a questionnaire series which evaluated the:
- frequency of occurrences encountered by participants
- extent to which participants formally reported occurrences
- the emotional impact and physical impact of occurrences
- the relevance of training to their practice setting
- the effectiveness of training to their practice setting
- confidence to manage aggression and violence

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

Results

The key findings from both strands of the study include that:
- The frequency of occurrences diminished significantly
- Injuries subsequent to occurrence decreased significantly
- Absenteeism subsequent to occurrence decreased significantly
- Participants confidence in managing aggression and violence significantly increased
- Participants highly rated the relevance of training to their practice setting

- Participants highly rated the effectiveness of training in their practice setting
- Participants emotional impact to occurrences remained unchanged
- Video recorded performance demonstrated significant improvement in effectiveness
- Video recorded performance demonstrated significant improvement in safety

The paper will present these findings and provide the opportunity for discussion of the implications, from professional and organizational perspectives.

Correspondence

Kevin McKenna
Dundalk Institute of Technology
Dublin Road,
Dundalk
County Louth
Ireland
+353-87-2334701
kevin.mckenna@dkit.ie

The integration of workplace violence simulation: Experiences into undergraduate nursing programs

Paper

Susan Solecki, Theresa Fay-Hillier
Drexel University, Philadelphia, USA

Abstract

Preparing student nurses to address violence in the health care workplace environment is a reality in current society. Unfortunately, most undergraduate nursing programs do not provide training in addressing and managing violence in the workforce. Some nursing programs provide training on addressing the impact of violence on patients, but lack preparing student nurses for managing themselves in the health care environment when confronted with bullying by managers or fellow colleagues, harassment, or aggression directed at them from patients, families, or coworkers. The use of simulation environments that include standardized patients (SP) can provide nursing students with enhanced learning opportunities, alternative means to complete course learning objectives, and evaluation methods of students' competency. The design and implementation of simulation scenarios that focus on assertive communication and behavior, conflict resolution, stress reduction, and management of episodes of workplace violence can be valuable and effective active learning tools for undergraduate nursing students. Evaluation methods of simulation experiences may include written student evaluations, verbal responses from nursing faculty, and feedback from the human standardized patients. The use of simulation as a non-traditional teaching strategy has significant potential to contribute to the enhanced application of nursing students' skill in addressing workplace violence and support their transition into their professional careers as safe and healthy care providers of the future.

Correspondence

Mrs Susan Solecki
Drexel University
1505 Race St, MS 501, Bellet Bldg
19102 Philadelphia
USA
01 215 762 3961
sms46@drexel.edu

Exposure to Workplace Violence: A Survey of Pediatric Residents

Paper & Poster

Karen Judy
Loyola University Medical Center, Maywood, USA

Introduction

The National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as "acts (including physical assaults and threats of assaults) directed toward persons at work or on duty" [1]. The health care sector leads all other industry sectors in incidence of nonfatal workplace assaults. Pediatric residents are positioned at the frontline of stressful interactions with parents and families who are under significant personal, financial, medical and emotional stress. Several recent incidents of violence or near-violence inspired us to attempt to document the prevalence of pediatric residents' experience with workplace violence. We hypothesize that residents are inadequately trained to handle such workplace violence and that they would benefit from further training in how to prevent and respond to workplace violence. It is our hope that the data generated from this study will help pediatric residency programs to plan specific educational interventions regarding workplace violence.

Methods

We recruited 25 US Pediatric Residency Program Directors in 2007. A convenience sample was selected. All Program Directors agreed to distribute a self-administered web-based questionnaire addressing resident exposure to verbal or physical abuse from patients and/ or patients' families to residents in their programs. The 25 item web-based questionnaire was given to residents in participating programs in 2007. The survey queried residents about their exposure to workplace violence, their reporting of such incidents, and whether action was taken against the perpetrator. Other questions included whether the incident impacted their ability to perform, whether others were involved in the incident(s), as well as the resident's training in workplace violence.
SPSS Version 13 (Chicago, IL) was used for data management and analysis. (Z-test)

Results

Participating programs ranged in size from 13 to 150 residents. Five hundred forty one of 1211 (45%) eligible residents completed the web-base questionnaire. Response rates according to year were: PL-1 (Postgraduate level) - 34%, PL-2 – 31%, and PL-3 – 31%. Chief Residents comprised four percent of the respondents. Seventy percent of respondents were female, and 91% were from academic residency programs. Thirty three percent of respondents (178 of 541) were verbally or physically assaulted by patients or patients' families during their residency training. Verbal abuse was more common that physical abuse. One hundred seventy four residents (32%) were verbally assaulted during their residency training, while only 50 (9 %) responded that they had been physically assaulted. (P < .0005). Residents were more likely to formally report verbal assaults than physical assaults. Of residents who responded that they had been verbally assaulted, 65 (37%) had formally reported the assault at their institution, while only 6 of 50 (12%) who were physically assaulted formally reported the assault. Table 1 lists to whom residents reported the assault.

Table 1: Official to Whom Resident Reported Assault

	Verbal Assault (123 responses)	Physical Assault (14 responses)
Attending	66% (n = 42)	67 % (n=4)
Nurse	41% (n=26)	33 % (n=2)
Senior Resident	39% (n=25)	50 % (n=3)
Security	38% (n=24)	83 % (n=5)
Other	9% (n=6)	0 % (n = 0)

Residents most commonly did not report verbal assaults because they felt it "would not matter" (42%) or they experienced "no loss of work" (33%). They did not report physical assaults because "they were not seriously injured." (n =1).

Twenty nine of 64 (45%) who reported verbal abuse also reported that action was taken against the perpetrator, but only one of 6 (17 %) reported that action was taken against the perpetrator of the physical assault. More residents reported that verbal abuse impacted their ability to perform their duties than those who were physical abused (39% versus 17%, P= 0.233).

Typically more than one hospital staff member was involved in the violent incident. One hundred percent of the residents who were verbally abused reported that other staff members were involved, and 83% of those who were physically assaulted reported that others were involved in the assault. Other staff members most often involved in verbal abuse incidents were as follows: Nurses (85%, n=34), other residents (65%, n=26), Ancillary staff (30%, n=12) and Medical students (13%, n=5). One person reported that nurses were also involved in the physical assault.

Seventy one percent of pediatric residents reported having no teaching about workplace violence during their residency training. The majority (74%) thought they would benefit from additional training in managing angry patients and families.

Discussion

Over a third of Pediatric residents experience some form of verbal and/or physical abuse from patient's families. Yet, the majority does not receive any formal training about workplace violence and managing angry patients and families. Workplace violence is an increasing concern in the health care sector. The Bureau of Labor Statistics (BLS) reported 97 homicides in the health services in 2006 [2]. Fortunately, the vast majority of workplace violence consists of non-fatal assaults. BLS data state that in 2000, 48% of all nonfatal injuries from occupational assaults and violent acts occurred in health care and social services. Nurses, aides, orderlies and attendants suffered the most non-fatal assaults resulting in injury [3]. Most of these occurred in hospitals, nursing and personal care facilities, and residential care services. Violence in Emergency Departments is not an uncommon phenomenon, with the majority of the incidents in the form of verbal threats or abuse [4]. Departments of Psychiatry experience a large number of violent episodes toward staff. In one study, 43% of respondents reported being threatened and 25% assaulted. Work experience was a protective factor but not a guarantee against violent events [5]. Another study states that more experienced clinicians often find ways to avoid working in settings with patients they suspect of having greater potential for violence [6]. In another study over half of psychiatrists reported that they had been exposed to violence during the course of the last year compared to three quarters of the nurses [7]. Although many health care workers believe that workplace violence is increasing, there is a paucity of data to support these claims due to low reporting rates.

Pediatric Residents often encounter potentially dangerous patients and/or families in the course of their work. Residents are often the first physician a patient will encounter during their illness experience. These patients often have psychiatric problems, are undergoing painful procedures, have a history of developmental delay or are trauma victims being treated for violent injuries. The increasing prevalence of handguns and other weapons among patients, families or friends also contributes to this problem. Families are often dangerous because they are dealing with stressful situations, have a history of psychiatric problems, may be involved in custody battles or domestic violence. Exposure to drugs and alcohol increase the risk of violent behavior. In families, when patients and visitors use healthcare services it is often with feelings of anxiety, frustration, and loss of control; they frequently encounter long waiting lines, high medical costs, fragmented services, and understaffed and frustrated workers. Pediatric residents' experience with workplace violence has not been well documented. A study in the Netherlands found that aggression in connection with pediatric care was reported by 78% of respondents, especially verbal aggression directed at doctors with little work experience [8]. A study of violence in the Pediatric Emergency Department (ED) found that 75% of pediatric ED directors reported one or more verbal threats per week. 77% reported one or more physical attacks on staff per year and 25% reported actual injury to staff [9].

Verbal abuse was more commonly reported by Pediatric residents than physical assault. In contrast, Gerberich and colleagues' reported a 15% rate of physical assaults against nurses [10]. Compared to physical assaults, non-physical violence is documented even less frequently. When healthcare workers are asked why they don't report workplace violence, they most commonly state that the incident is not associated with injury or lost work. Reporting is said to be too time-consuming, lacks supervisory support, and reporting won't make any difference [11].

Interestingly, in our study, more residents reported that verbal abuse impacted their ability to perform than those who were physically abused. Researchers including Gerberich, et al, found that the negative consequences associated with such violence are substantial. Healthcare workers' experiences with non-physical and physical violence are increasingly recognized for their association with decreased job satisfaction, increased occupational strain, and poor patient care outcomes [12]. More healthcare workers than ever are suffering from symptoms of post-traumatic stress disorder [13]. Although most physical injuries heal relatively quickly, psychological and emotional wounds may linger and interfere with normal working and leisure lifestyle for months or years after the incident.

The survey design of our study has several limitations. Our data is based on resident recall of events, so possibly under-represents the true incidence of verbal and physical assaults. It is possible that the respondents were biased in the direction of greater experience with and concern about workplace violence. In addition, many residents did not complete the entire survey resulting in smaller sample size for some items.

Despite the prevalence, 70% of US workplaces do not have a formal program or policy that addresses workplace violence [14]. The high incidence and adverse consequences of verbal and physical assaults in addition to the lack of formal teaching on workplace violence suggests that all Pediatric Residents should receive training in recognition, management and prevention of workplace violence. A curriculum on workplace violence and managing difficult situations should be implemented. Violence must not be tolerated in our Pediatric Training Institutions.

Acknowledgements

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Correspondence

Mrs Karen Judy
Loyola University Medical Center
2160 S. First Ave
60153
Maywood
USA
+1 708 327 9131
kjudy@lumc.edu

Announcement

The Third International Conference on Violence in the Health Sector will be held on the 24th till the 26th of October 2012 in Vancouver, Canada.

The call for abstracts will be issued in October 2011.

Please reserve these important dates in your agenda.

We look forward to seeing you in Vancouver in 2012.

From awareness to sustainable action

- As many as 72% of nurses do not feel safe from assault at work (ICN).
- Health-care professionals are at the highest risk for being attacked at work, even when compared to prison guards, police officers, or bank personnel (Kingma).
- Tens of thousands of women each year are subjected to sexual violence in health care settings (WHO).
- Whilst the rate of horizontal (care-worker to care-worker) violence and bullying remains unknown, these behaviours are widespread and can have devastating effects at personal, group and organisational levels (McKenna 2004).
- In a survey of 127 hospitalised psychiatric patients 50% reported experiences of abuse either by other patients or by staff (Lucas and Stevenson).

These findings reflect the growing global recognition of the scale and magnitude of the problem of workplace aggression and violence within healthcare and the challenges it poses for professional, regulatory, and organizational stakeholders. These stakeholders include governments, management, professionals, health care workers, trade union organization, insurance companies, clients, educators, trainers, researchers, the police, and others. Despite the diversity of stakeholder perspectives, all strive to develop and implement effective responses.

The second conference on Violence in the Health Sector provides a forum for stakeholders to exchange their experiences, strategies, and research work. In addition to archiving the presentations of impressive work being done around the globe, this book of proceedings will also contribute to a corpus of knowledge which can inform effective sustainable actions toward the reduction of violence in the health sector beyond the temporal or the geographical boundaries of the conference itself.

Dr. Ian Needham
Mr. Kevin McKenna
Dr. Mireille Kingma
Mr. Nico Oud

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