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Workplace aggression experiences of Victorian nurses and midwives in non-metropolitan settings

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Abstract

Aims: Workplace aggression remains an intractable feature of clinical practice across the health and care sectors. Nurses, midwives and other frontline carers are at high risk of exposure to aggression at work, occasionally with fatal consequences. There is contention in the literature about the relative risks of exposure to workplace aggression in non-metropolitan compared to metropolitan care settings. Drawing on the results of a large mixed methods study of workplace aggression experiences of Victorian nurses and midwives, this presentation aims to highlight differentiating factors for clinicians working in non-metropolitan settings, which have emerged from both the quantitative and qualitative findings of the study.

Methods: The Workplace Aggression Experiences of Victorian Nurses and Midwives study initially utilised a cross-sectional survey design. Over 1200 respondents provided self-report estimates of exposure to aggression from external sources (patients, relatives/carers and others) and internal sources (co-workers), as well as their responses to incidents of aggression. Exposure rates were compared across Australian Standard Geographical Category (ASGC) classifications for respondents' main workplaces. Almost 600 respondents provided unsolicited comments on their experiences and additional, in-depth interviews were conducted, which provided very personal accounts of the sources, impacts and consequences of aggression at work.

Relevance: Understanding the differences between rural and metropolitan settings is important, particularly in relation to key issues of concern, which can be critical determinants of decision-making about continuing to provide patient care or remaining in the profession.

Results: Differences in prevalence across the geographical classifications of main workplaces were detected, although these were not statistically significant. Qualitative findings provided particularly important insights, however. For nurses working in regional and rural areas, raising 'unpleasant' workplace issues could cause much deeper problems, especially where people working for or associated with local health and care services all know each other, and their privacy could not be maintained. As alternative employment options are often non-existent, only avoidance strategies can be used. Additionally, access to security and legal services in regional and rural services can be quite restricted. Thus, the notions of 'risk', 'safety' and 'security' for non-metropolitan clinicians can be considerably more complex than for clinicians working in metropolitan settings.

Conclusions: Workplace aggression in the health and care sectors is a major work health and safety, and public health concern, especially in non-metropolitan settings. More targeted and effectively operationalised legislation, policy, incentives and penalties are required to prevent or minimise the likelihood and consequences of this truly wicked problem.

Introduction

Worldwide, workplace aggression remains an intractable feature of clinical practice across the health and care sectors. Nurses, midwives and other frontline carers are at high risk of exposure to aggression at work, with concerning and occasionally fatal consequences.[1-7] The physical and emotional impacts of sustained exposure can lead to disengagement from the workplace, resulting in alienation and decisions to change employment or leave the profession altogether.[8-10] In Australia, rates of exposure to workplace aggression are consistent with those experienced by nurses internationally, and have not decreased over the past 35 years.[11-14] Despite the body of work examining workplace aggression in nursing, few studies have documented nurses' and midwives' own voices, their direct experiences of workplace aggression, their descriptions of reporting aggression in the workplace, or their experiences of seeking advice and support from their employers, professional organisations, work health and safety authorities, police or other legal services.[8] A further issue relates to the voices of nurses in non-metropolitan settings, especially considering the contention in the literature about the relative risks and consequences of exposure to workplace aggression in non-metropolitan compared to metropolitan care settings.[15]

Undertaken as a component of the Workplace Aggression Experiences of Victorian Nurses and Midwives survey[14], the aim of this sub-study was to explore and describe differentiating factors for nurses, midwives and care personnel working in non-metropolitan settings, which have emerged from both the quantitative and qualitative findings of the larger study to date.

Methods

The Workplace Aggression Experiences of Victorian Nurses and Midwives study initially utilised a cross-sectional survey design. An online survey of the membership of the Australian Nursing and Midwifery Federation – Victorian Branch was conducted between 1st May and 30th June 2017, with over 1200 members responding. Respondent profile data, self-report estimates of exposure to aggression from external sources (patients, relatives/carers and others) and internal sources (co-workers), and responses to incidents of aggression have been reported elsewhere.[14] The definition of workplace aggression was adapted from that used in a national study of Australian clinical medical practitioners.[16,17] Frequency of exposure was elicited with a five-point ordinal scale, with the response options of 'Frequently (once or more each week)', 'Often (a few times each month)', 'Occasionally (a few times each six months)', 'Infrequently (a few times in 12 months)' and 'Not at all'.[14] In the current sub-study, 12-month prevalence rates of workplace aggression were compared across Australian Standard Geographical Category (ASGC) classifications of respondents' main workplaces by aggression source. Comparisons were undertaken using the Kruskal-Wallis test, correcting for ties.

In the survey questionnaire, space was provided for comments at the end of each section in free-form fields to enable respondent comments to be extracted for later, qualitative analysis. A final item asked whether respondents were willing to undertake a personal, in-depth interview with a member of the research team. Almost 600 survey respondents provided unsolicited comments on their experiences and additional, in-depth interviews were conducted with 29 survey respondents between June and December 2017. The comments and interviews provided often very personal

accounts of the sources, impacts and consequences of aggression at work. De-identified qualitative data relating to issues of concern in regional and rural settings were extracted for the purpose of the current sub-study and thematic analysis was applied. In the reporting of quotations, the prefix 'R' refers to comments by online questionnaire respondents while the prefix 'C ' refers to participants who were interviewed by members of the research team.

The conduct of the overall study was approved by the Monash University Human Research Ethics Committee. The study conformed to the National Statement on Ethical Conduct in Human Research 2007.[18]

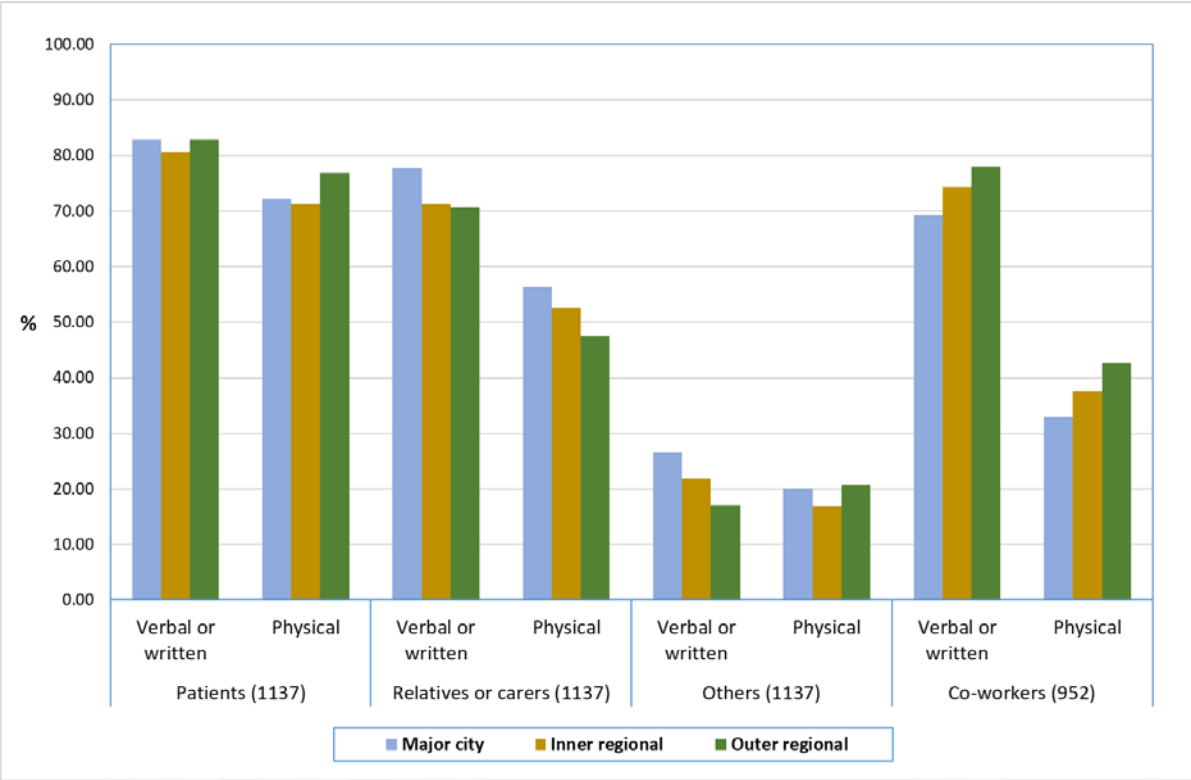
Results

In relation to aggression exposure from external sources, 1137 respondents provided data on exposure to aggression from patients, patients' relatives or carers and others external to the workplace, while 952 respondents provided data on exposure to aggression from co-workers. Respondent proportions by ASGC classifications are reported in Table 1. 'Major city' is described as metropolitan, whereas 'inner regional' and 'outer regional' are described as regional and rural (non-metropolitan). There were no remote or very remote residents. Differences in 12-month prevalence of exposure to workplace aggression across the geographical classifications of respondents' main workplaces were detected (Figure 1), but none were found to be statistically significant. Despite this, the qualitative findings provided particularly important insights on the impact and consequences for nurses, midwives and other care personnel working in regional and rural locations.

Table 1 Comparison of 12-month prevalence of workplace aggression exposure by ASGC classification

ASGC category	External aggression (n=1177)	Internal aggression (n=952)
Major city	67.4%	66.6%
Inner regional	25.4%	26.3%
Outer regional	7.2%	7.1%

Figure 1 **Comparison of 12-month prevalence of workplace aggression exposure by source and rurality**



A cross-cutting theme emerging from the free-text and interview data related to the population size of regional and rural locations, which played out in a number of ways to impact on the risk of exposure and the resulting consequences of exposure. For example, in the clinical context, the interplay of restricted staffing levels and changing service demands could affect response times in rural ED settings, as highlighted by C2:

> I guess a combination of me and my colleagues being overworked and stressed … and patients waiting a long time leads to a clash, and you get that kind of violence happening.

The key concern for respondents working in regional and rural areas, however, was that raising challenging workplace issues could cause much deeper problems, especially where people working for or associated with local health and care services all know each other, and privacy could not be maintained. Of particular concern was the inability to find alternative employment when exposure to aggression was not able to be sufficiently or effectively managed. For R493, working in a specialty area, 'There are not a lot of employers for mental health nurses in the region … the public hospital is the only employer between the border and Melbourne.' As explained by C2, 'I'm in a situation where the hospital is the largest public employer in the area, so there is not much ability to move around to get away from potentially toxic people'. Similarly, for C11, 'I have not reported incidents of … aggression from fellow staff members because I live in the rural area that I work in. If things became really difficult at work, then that limits my choice if I had to leave ... I'm too scared.'

Where acts of aggression were serious enough to consider taking legal action against the perpetrator, the fear of not being able to continue working in that department or service can override the need or desire to seek legal redress. As explained by R270, 'To take legal action would be the death of my professional life ... even if I did win, I would be blacklisted and unable to get any

work'. For R16, 'Actions against management have poor outcomes and result in being forced to relocate home and workplace due to limited options in rural/remote location'. Yet, when needing to leave because of aggression in the workplace, people did leave but with less than ideal outcomes. As R62 described:

> Rural Health services are very inbred, mostly staffed and administered by locals who are related or close friends. This causes a closed shop mentality of do it their way or leave. Staff turnovers are huge and nursing positions are filled with 457 visa staff as a result of this.

A further concern expressed by some respondents living in regional and rural areas was that their privacy could not be maintained, with the implication of a level of risk to their safety. For example, as stated by R369, 'Patients and family know who you are and often where you live or at the least can access you through social means'. The issue of safety in regional and rural settings, where security services are restricted or not present, was also raised as an issue of concern. For example, as R16 reported, 'Lock down after hours but open access 8am to approximately 8pm without reception staff after office hours and no security staff employed in any format'.

Clearly, respondents in regional and rural areas of Victoria were very aware of the need to make choices about whether or not to pursue any form of redress in relation to exposure to workplace aggression, be it from internal or external sources. The two main approaches described above comprised just accepting the aggression, typically without redress or change in working conditions, and leaving the job, which might mean leaving town. A third approach described, however, concerned the use of avoidance strategies. As C22 reported, 'If I know there are difficult people there, as I'm casual, I will choose not to work on that shift'.

Discussion

As with their metropolitan counterparts, non-metropolitan nurses, midwives and care personnel reported frequent verbal and physical assaults by patients in their care and the patients' relatives or carers. They also experienced high levels of exposure to acts of aggression from co-workers and managers, with rates trending higher with increasing rurality. Respondents expressed feelings of powerlessness to take action either through the organisational systems and processes or through legal channels. This was not just because systems and processes to deal with aggression exposure were ineffective or were bypassed, but also because of the perceived fraternity of senior personnel who were collectively unable or unwilling to act in support of the targeted personnel.

Smaller, non-metropolitan services clearly have some resource limitations, such as in the provision of security personnel, which can only heighten perceptions of risk, especially where less senior personnel do not feel they have support from more senior managers or even peers. Further, in smaller communities, significant privacy concerns cannot be discounted, especially where personnel do not feel confident that they will be supported or protected when calling out aggressive and violent behaviour from patients or their relatives, or from their colleagues. The results of this sub-study suggest that the fears, anxieties and impacts of working in remote nursing settings, as reported by Opie et al.[19,20], are likely more widely shared by personnel working outside of metropolitan settings. Additionally, as highlighted previously, levels of exposure to aggression in health and other care settings appear to be steadily increasing.[14,20,21]

More than 30 years ago, Holden[11] offered a set of recommendations to address workplace aggression in health care. Overall, these recommendations are reflected in the Australian Nursing and Midwifery Federation policy on preventing workplace aggression and violence.[22] Additionally, WorkSafe employer guidelines describe strategies for preventing and minimising workplace

aggression in care settings in accordance with legislative provisions for work health and safety.[23] While evidence on the efficacy of some aggression prevention and minimisation strategies may be equivocal, it is more likely that there is currently a failure to properly implement co-ordinated, multi-sectorial and targeted interventions in non-metropolitan care settings in Victoria.[14,15,24]

Victorian nurses, midwives and care personnel in non-metropolitan settings both deserve and have a legal right to work in safe, supportive work cultures and environments. Yet it seems that are significant issues that need to be urgently addressed, in spite of existing policies and legislation. Understanding the differences between working in non-metropolitan and metropolitan settings is important, particularly in relation to key issues of concern such as the prevalence and impact of workplace aggression, which can be critical determinants of decision-making about continuing to provide patient care or remaining in the profession.[15,25] The notions of 'risk', 'safety' and 'security' for non-metropolitan clinicians can be considerably more complex than for clinicians working in metropolitan settings. There is a need to strengthen and enforce existing legislation and introduce new, enforceable laws that adequately protect the health and safety of regional and rural nurses, midwives and other care personnel in their work. There is also a need to strengthen the evidence base for interventions that can prevent and minimise workplace aggression in care settings This will necessarily require sufficient investment in more rigorous research into this significant professional and community health and safety concern.

This sub-study has some limitations. In the quantitative component of the study, sampling biases may have contributed to an overestimate of the population prevalence of workplace aggression. Although a definition of workplace aggression was provided, respondents' perceptions of experiencing aggression from each source were nonetheless important. Questionnaire items were designed to elicit realistic estimates of exposure in a range, rather than exact frequencies, so recall bias was minimised. As a descriptive study, analyses of associations between different variables were neither conducted nor reported. In relation to the qualitative component of the sub-study, thematic analyses of combined responses from 676 survey participants who provided commentary in free-text boxes in an online questionnaire and from transcripts of interviews with a purposive sample of 29 survey participants provided the database from which data relating to experiences in regional and rural settings were extracted. Overall, no claim can be made that the responses are representative of the non-metropolitan population of nurses, midwives and care personnel in the State of Victoria or Australia more broadly.

Conclusion

Workplace aggression in the health and care sectors is a major work health and safety, and public health concern. This is especially so in non-metropolitan settings, where there are fewer or no appropriate alternative workplaces to seek employment, and where there are fewer or no resources or capabilities to address privacy and security concerns of care personnel. More targeted and effectively operationalised legislation, policy, incentives and penalties are required to prevent or minimise the likelihood and consequences of this truly wicked problem. This could be supported by further research into the efficacy of a range of aggression prevention and minimisation strategies.

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Presenter

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