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Postincident Support for Healthcare Workers Experiencing Occupational Violence and Aggression

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Abstract

Purpose: To investigate the relative contributions of workplace type, occupational violence and aggression (OVA) strategies and interventions along with perceptions of the occupational health and safety (OHS) environment on the likelihood of receiving postincident support following the experience of OVA.
Design: We used a cross-sectional study design with an online survey to collect data from employees in nursing and midwifery in Victoria, Australia.
Methods: Survey data collected from 3,072 members of the Australian Nursing and Midwifery Federation (Victorian branch) were analyzed using logistic regression.
Findings: Of the 3,072 respondents who had experienced OVA in the preceding 12 months, 1,287 (42%) reported that they had received postincident support. Hierarchical logistic regression revealed that the OHS environment was the dominant factor that predicted the likelihood of workers receiving postincident support. Working in a positive OHS environment characterized by higher levels of leading indicators of OHS, prioritization of OHS, supervisor support for safety, and team psychological safety was the stronger predictor of postincident support. Being employed in a workplace that offered training in the management and prevention of OVA also increased the likelihood of receiving postincident support.
Conclusions: While training in the management and prevention of OVA contributed to the likelihood of receiving postincident support, a greater emphasis on the OHS environment was more important in predicting the likelihood that workers received support.
Clinical Relevance: This study identifies workplace practices that facilitate the provision of postincident support for healthcare workers. Facilitating effective postincident support could improve outcomes for workers, their patients and workplaces, and society in general.

The healthcare workforce in Australia is large and diverse, spanning many occupations. Nurses and midwives represent over half of all registered healthcare practitioners, with nursing being the largest single healthcare profession in Australia (Australian Institute of Health and Welfare [AIHW], 2012). A dominant concern for members of this group is their exposure to occupational violence and aggression (OVA). Recent Australian research

indicates that 67% of Australian nurses reported experiencing OVA in the preceding 12 months (Shea, Sheehan, Donohue, Cooper, & De Cieri, 2017), a level consistent with global trends (Spector, Zhou, & Che, 2014). Compared with workers in other industries, those employed in health care experience some of the highest levels of work-related violence (LeBlanc & Kelloway, 2002).

Organizational support is essential for employees who experience OVA (Azar, Badr, Samaha, & Dee, 2016; De Puy et al., 2015; Leather, Lawrence, Beale, Cox, & Dickson, 1998; Schat & Frone, 2011). AbuAlRub and Al-Asmar (2011) and Campbell (2011) highlighted the importance of postincident support at the organizational level as opposed to informal support mechanisms. Moreover, a recent report by the International Labour Organization called for government intervention to ensure organizations were obliged to provide postincident support to workers affected by OVA (Pillinger, 2017). However, there is little information within the literature about specific organizational-level factors that impact on the likelihood of receiving postincident support. Identifying the specific organizational-level factors that increase the likelihood of healthcare workers receiving postincident support can guide healthcare organizations in developing supportive interventions, strategies, and climates. The purpose of this research is to address this gap.

Impact of and Response to OVA

The experience of OVA has been reported to affect not just the individual but also to have an impact at the organizational and societal levels. For the individual, Lanctôt and Guay's (2014) literature review indicated that the personal consequences of OVA are wide ranging and include physical, psychological, emotional, financial, and social problems. The experience of OVA has been associated with posttraumatic stress disorder and burnout (Chen, Lin, Ruan, Li, & Wu, 2016), stress (Woodrow & Guest, 2012), anxiety (Magnavita & Heponiemi, 2011), and depression (Ünsal Atan et al., 2013). Lanctôt and Guay (2014) also found that the experience of OVA may have a detrimental impact on work functioning of healthcare workers. OVA has been associated with reduced job satisfaction (Woodrow & Guest, 2012), increased intention to leave (Woodrow & Guest, 2012), and reduced organizational commitment (Madlock & Kennedy-Lightsey, 2009).

For the organization, the impact of aggression at work can lead to decreases in employee job performance (Schat & Frone, 2011), productivity (Cashmore, Indig, Hampton, Hegney, & Jalaludin, 2012), and reputation (Hoel, Sparks, & Cooper, 2001), as well as increases in absenteeism (O'Connell, Young, Brooks, Hutchings, & Lofthouse, 2000) and employee turnover (Quine, 1999). For healthcare organizations, it has been established that nurses who experience OVA have a reduced capacity to function in their workplace and care for their patients (Roche, Diers, Duffield, & Catling-Paull, 2010). Disruptions to patient care following a violent or aggressive incident have also been identified (Chapman, Perry, Styles, & Combs, 2008).

The impact of OVA has been reported to go beyond individuals and their workplaces to society in general. While it is difficult to estimate costs to society, tangible expenses associated with OVA might include the medical costs of physical or psychological injury and injury compensation costs (Hoel et al., 2001). The damage associated with the loss of skilled workers who leave their job prematurely due to stress or incapacitation may be both tangible, in the form of government benefits paid to employees who have ceased working, or intangible, with the loss of skills to a profession (Hoel et al., 2001).

Responses to OVA in the Australian healthcare industry have been developed by government (Victorian Auditor General's Office, 2015) and trade unions (Australian Nursing and Midwifery Federation [ANMF], 2015). For example, in Australia, the Victorian State Government established the Violence in Healthcare Taskforce to investigate how to reduce violence in hospitals. The report by the Taskforce placed emphasis on the creation of cultural change "through raising awareness of the issue, building the knowledge and competency needed to act and by taking action to change" (Violence in Healthcare Taskforce, 2016, p. 3). Leadership and accountability were considered by the Taskforce to be critical in determining such change. Additionally, the ANMF has released a detailed policy statement for the prevention of OVA in the workplace (ANMF, 2015). This statement, which emphasizes a zero-tolerance approach to OVA, addresses pre-emptive measures (e.g., implementation of systems and practices to prevent OVA) and postincident responses (e.g., reporting and support for staff) to reduce the impact of OVA on affected workers. Despite these investigations and recommendations, presently there is limited evidence from academic research on the influence of organizational-level activities on the prevention of OVA in the healthcare field (Hills & Joyce, 2013) or types of incident support that are offered to workers.

Postincident Support

Importantly, a small, but growing, body of literature indicates there is value in positive workplace strategies and interventions to reduce the impact of OVA, or unsafe work environments, on psychological and work functioning. These workplace factors include

organizational support (Azar et al., 2016; De Puy et al., 2015; Leather et al., 1998; Schat & Frone, 2011), peer support (Purpora & Blegen, 2015; van Emmerik, Euwema, & Bakker, 2007), and critical incident stress debriefing (Paterson, Leadbetter, & Bowie, 1999). When OVA does occur, perceptions of support from the organization are critical, as this can buffer the negative effects of OVA on employee well-being, job satisfaction, and organizational commitment (Leather et al., 1998), while administrative support has been reported to buffer the effects of OVA on nurses' stress and intention to leave (Azar et al., 2016). Despite the importance of such support, there is very little research into the factors that determine whether support is offered following an incident of OVA.

Two earlier studies that did not examine postincident support directly, but gave nurses the opportunity to report on postincident support, found that help following an incident came from both informal sources such as peers, family, and friends (O'Connell et al., 2000) and formal sources such as the employer or supervisor (AbuAlRub & Al-Asmar, 2011). However, O'Connell et al. (2000) found nurses were largely unaware of the mechanisms for obtaining postincident support that were available to them, and AbuAlRub and Al-Asmar (2011) highlighted the absence of follow-up to an aggressive incident.

Campbell (2011), in research using semistructured interviews with nurses, studied the relative importance of the kind of postincident support nurses received following OVA. They found that although the dominant source was peer support, broader organizational support was valued but did not necessarily occur. De Puy et al. (2015) also studied the relative importance of multiple sources of support (i.e., friends, colleagues, and employer) on the impact severity of OVA (i.e., physical, psychological, and work consequences) in a sample of healthcare workers. Their study showed that a perceived lack of organizational support following the experience of OVA increased the impact severity of OVA. The interesting outcome of this study was that, while they measured support from family and friends, colleagues, and the employer, it was only support from the employer that significantly reduced the impact of OVA. That is, employer support after the experience of OVA led to reduced impact severity and, consequently, the possibility of preventing negative outcomes for the target.

The aim of this article, therefore, is to provide greater detail on the role of specific organizational-level factors that impact on the likelihood of receiving postincident support. We examine the following research question: After controlling for demographic characteristics, what is the relative contribution of workplace type (e.g., public hospital) along with specific OVA strategies and interventions compared to the broader occupational health and safety (OHS) environment (e.g., leading indicators of OHS) in predicting the likelihood that employees will receive postincident support following the experience of OVA?

Methods

Sample and Procedure

The sample for this study was drawn from a larger project investigating OHS in the nursing and healthcare profession. All members of the ANMF branch in Victoria Australia were invited to participate in an OHS survey, which was conducted online. In the total sample, 69,927 members had the opportunity to participate in the survey, and responses were received from 4,891 members (7% response rate). The subset of the sample used in the present study was composed of the 3,072 of respondents who reported experiencing OVA at least once in the past year. The project was approved by the university's Human Research Ethics Committee, and all respondents were assured of confidentiality and anonymity.

Due to the anonymous nature of the survey, respondents could not be directly compared with nonrespondents. However, nonresponse bias was tested using wave analysis, where we compared early responders (first 2 weeks of the survey, $n = 1{,}049$), middle responders (third week of the survey, $n = 1{,}223$), and late responders (last 2 weeks of the survey, $n = 743$) on the dependent variable, postincident support (see next section). Comparing early and late responders is a commonly used technique for testing nonresponse bias (Rogelberg & Stanton, 2007). We conducted a chi-square test with responder type (early, middle, and late) as the independent variable and postincident support (yes, no) as the dependent variable. There were slight differences in the percentages of early (60%), middle (55%), and late responders (58%) who said that they had not received postincident support, but these differences were not statistically significant, $\chi^2(2) = 4.8$, $p = .092$. This result suggests that the sample is not significantly biased.

Measures

After responding to demographic questions including gender, age, and job role (e.g., registered nurse), respondents were asked, "Have you experienced occupational violence and/or aggression at your workplace during the last 12 months?" (1 = *yes, daily*; 2 = *yes, weekly*; 3 = *yes, monthly*; 4 = *yes, a few times*; 5 = *no, never*). Responses to this item were collapsed to create a binary variable (coded 1 = *yes*, 0 = *no*). If the respondent reported experiencing

OVA in the past 12 months, they were also asked whether postincident support was provided to them following the incident (coded 1 = *yes*, 0 = *no*).

Workplace type, OVA strategies, and interventions. Workplace type was measured with a single item: "From the list below, please select the type of organisation where you mainly work (public hospital, private hospital, aged care facility, general practice, local government, community or other)." Respondents were asked to select one option only. OVA strategies and interventions were measured by two items: "Does your workplace have occupational violence and aggression prevention and management policies?" (coded 1 = *yes*, 0 = *no*); and "Do you receive training in the management of occupational violence and aggression (or the like)?" (coded 1 = *yes*, 0 = *no*).

Perceptions of the OHS environment. The four measures used to examine worker perceptions of their OHS environment included the Organizational Performance Metric–Monash University (OPM-MU; Shea, De Cieri, Donohue, Cooper, & Sheehan, 2016), a measure of supervisor support for safety (Lauver, Lester, & Le, 2009), a measure of prioritization of OHS (Sheehan, Donohue, Shea, Cooper, & De Cieri, 2016), and a measure of team psychological safety (Edmondson, 1999). The OPM-MU (Shea et al., 2016) is an adaptation of the Institute for Work and Health–Organizational Performance Metric (Institute for Work & Health, 2011) and contains eight items measuring leading indicators of OHS (e.g., workers and supervisors have the information they need to work safely). The items are rated on a 5-point scale from "*strongly disagree*" (1) to "*strongly agree*" (5). The study by Shea et al. (2016) showed that this scale is a reliable and valid measure of OHS leading indicators. The OPM-MU has excellent reliability ($\alpha = .91$).

The supervisor support for safety scale is a three-item measure rated on a 5-point frequency scale from "*not at all*" (1) to "*a great extent*" (5) and has excellent reliability ($\alpha = .96$). The three items of the prioritization of OHS scale were rated on a 5-point scale ranging from "*strongly disagree*" (1) to "*strongly agree*" (5), and the measure has excellent reliability ($\alpha = .97$; Shea, Sheehan, Donohue, Cooper, & De Cieri, 2017). The measure for team psychological safety was a seven-item scale. The items are rated on a 7-point scale from "*very inaccurate*" (1) to "*very accurate*" (7). The study by Edmondson (1999) showed this scale to be a reliable and valid measure of psychological safety. We found this measure of team psychological safety to have acceptable reliability ($\alpha = .69$).

Table 1. Characteristics of the Respondents and Their Workplaces

Demographic		*n*	%
Gender	Male	239	8
	Female	2,816	92
Age	18–25 years	110	4
	26–35 years	351	12
	36–45 years	541	18
	46–55 years	1,136	37
	56+ years	927	30
Job role	Registered nurse	2,021	66
	Enrolled nurse	694	23
	Midwife	248	8
	Personal carer	109	4
Workplace type	Hospital public	1,711	58
	Hospital private	304	10
	Aged care facility	654	22
	General practice clinic	72	3
	Local government	31	1
	Community	163	6
OVA policy	Policy (yes)	2,708	90
OVA training	Training (yes)	2,036	67

Statistical Analysis

Analysis included (a) summary statistics to examine the distribution of the study variables, (b) correlations between study variables to examine the inter-relationships among these variables, and (c) a three-stage hierarchical logistic regression analysis to examine the likelihood of receiving postincident support following the experience of OVA. The first stage included demographic predictors: gender, age, and job role. The second stage included workplace type, OVA prevention and management policy, and OVA training. The third stage included the predictors measuring respondent perceptions of their OHS environment: leading indicators of OHS, prioritization of OHS, supervisor support for safety, and team psychological safety. All analyses were conducted using SPSS version 24.0 (IBM Corp., Armonk, NY, USA).

Results

Characteristics of the Respondents

Overall, 3,072 (67%) of respondents to the survey indicated that they had experienced OVA in the preceding 12 months, and it is this subset that forms the basis of the study. Of the respondents who had experienced OVA in the preceding 12 months, 1,287 (42%) reported that they had received postincident support. **Table 1** summarizes characteristics of the respondents and shows that nearly all respondents were female. More than half were 46 years of age or older, and most reported working as registered nurses or enrolled nurses. With respect

Table 2. Means, Standard Deviations, and Correlations Among the Study Variables

	M	*SD*	1	2	3	4	5	6	7	8	9
1. Gender	0.92	0.27									
2. Age	3.79	1.10	**.04***								
3. OVA policy	0.90	0.31	−.02	.02							
4. OVA training	0.67	0.47	.02	**.05***	**.43****						
5. Postincident support	0.43	0.50	.01	.02	**.14****	**.20****					
6. Team psychological safety	4.19	1.15	.03	−.00	**.10****	**.16****	**.33****	(.69)			
7. OPM-MU	3.30	0.86	**.05***	.03	**.20****	**.26****	**.39****	**.50****	(.91)		
8. Prioritization of OHS	2.92	0.44	.03	.02	**.11****	**.16****	**.38****	**.46****	**.59****	(.97)	
9. Supervisor support	3.41	1.06	.02	**.04***	**.17****	**.22****	**.40****	**.53****	**.68****	**.56****	(.96)

Note. $N = 3{,}072$. Cronbach's alphas are on the diagonal. Boldfaced values denote statistically significant correlations. Gender coded 0 = male, 1 = female; age coded 1 = 18–25 years, 2 = 25–35 years, 3 = 36–45 years, 4 = 46–55 years, 5 = 56 or more years; OVA policy, OVA training, and postincident support coded 0 = no, 1 = yes. OHS = occupational health and safety; OPM-MU = Organizational Performance Metric–Monash University; OVA = occupational violence and aggression.

*$p < .05$; **$p < .01$.

to workplace type, respondents tended to report that they worked in public hospitals or aged care. Nearly all respondents reported that their workplaces had an OVA prevention and management policy in place, and most had received training in the management of OVA. The sample characteristics are highly consistent with national statistics on the nursing and midwifery workforce in Australia (AIHW, 2012).

Organizational Level Factors and Postincident Support

Table 2 displays the means, standard deviations, and correlations among the study variables (excluding the two categorical variables of job role and workplace type). As shown in this table, respondents who received postincident support tended to report being employed in workplaces that had OVA prevention and management policies and had completed training in OVA management and prevention. They also tended to obtain higher scores on the OPM-MU, prioritization of OHS, supervisor support for safety, and team psychological safety scales.

Table 3 displays the results of the hierarchical logistic regression. In all stages of the model, the relationship between the predictor variables and the experience of postincident support was significant ($p < .001$), and the -2 log likelihood value decreased from 3,798.11 in Model 1 to 3,126.64 in Model 3. The explained variance (Nagelkerke R^2) for the models were 1% in Model 1, 7% in Model 2, and 29% in Model 3.

The odds ratios (*OR*s) from Model 3 showed that respondents 36 to 45 years of age were less likely than the youngest employees (18–25 years) to have received postincident support ($OR = 0.59$, 95% confidence interval [CI] 0.36–0.95). The *OR*s for gender and job role were not statistically significant. Turning to workplace type, respondents working in general medical practice ($OR = 2.10$, 95% CI 1.17–3.79) were more likely to have received postincident support than those who were employed in public hospitals. With regard to OVA strategies and initiatives, respondents who reported that they had received training in the management of OVA ($OR = 1.56$, 95% CI 1.27–1.92) were more likely to have received postincident support. The presence of an OVA prevention and management policy was not a significant predictor of postincident support ($p > .05$). In general, the broader OHS environment tended to have a much stronger impact on the likelihood of receiving postincident support, compared to workplace type, and OVA strategies and interventions. Respondents employed in workplaces with higher levels of OHS leading indicators ($OR = 1.50$, 95% CI 1.29–1.74), higher levels of supervisor support for safety ($OR = 1.56$, 95% CI 1.38–1.76), a greater prioritization of OHS ($OR = 1.70$, 95% CI 1.35–2.14), and higher levels of team psychological safety ($OR = 1.32$, 95% CI 1.20–1.45) were also more likely to receive postincident support.

Discussion

The results of this study show that while the experience of OVA is pervasive in the healthcare sector, fewer than half of those who experienced OVA reported that they had been given postincident support. This article sought to understand the relative contributions of workplace type, specific OVA strategies and interventions, and the broader OHS environment in predicting the likelihood that respondents would receive postincident support after the experience of OVA. Logistic regression analyses showed that personal characteristics of the

Table 3. Hierarchical Logistic Regression Predicting the Likelihood of Postincident Support

	Model 1 *OR* (95% CI)	Model 2 *OR* (95% CI)	Model 3 *OR* (95% CI)
Block 1. Demographics			
Female	1.09 (0.82–1.44)	1.08 (0.81–1.44)	1.00 (0.73–1.39)
18–25 years	Reference category	Reference category	Reference category
26–35 years	**0.62 (0.40–0.97)***	0.67 (0.43–1.08)	0.61 (0.37–1.01)
36–45 years	**0.64 (0.42–0.97)***	**0.63 (0.41–0.98)***	**0.59 (0.36–0.95)**
46–55 years	0.68 (0.45–1.02)	0.67 (0.44–1.01)	0.63 (0.40–1.01)
56+ years	0.76 (0.51–1.15)	0.73 (0.48–1.10)	0.64 (0.40–1.03)
Registered nurse	Reference category	Reference category	Reference category
Enrolled nurse	1.06 (0.88–1.28)	1.09 (0.88–1.33)	1.09 (0.87–1.38)
Midwife	**0.72 (0.54–0.96)***	**0.72 (0.53–0.97)***	0.93 (0.67–1.28)
Personal carer	0.66 (0.44–1.00)	0.80 (0.50–1.26)	1.05 (0.63–1.75)
Block 2. Workplace type, OVA strategies, and interventions			
Hospital public		Reference category	Reference category
Hospital private		0.79 (0.60–1.03)	0.85 (0.63–1.14)
Aged care		1.11 (0.89–1.39)	1.02 (0.80–1.32)
General practice		**2.318 (1.39–3.86)****	**2.10 (1.17–3.79)**
Local government		1.42 (0.68–2.97)	1.23 (0.54–2.78)
Community		**1.47 (1.05–2.07)***	1.28 (0.87–1.88)
OVA policy		**1.78 (1.29–2.45)****	1.41 (1.00–2.00)
OVA training		**2.15 (1.79–2.59)****	**1.56 (1.27–1.92)****
Block 3. Perceptions of the OHS environment			
OPM-MU			**1.50 (1.29–1.74)****
Prioritization of OHS			**1.70 (1.35–2.14)****
Supervisor support			**1.56 (1.38–1.76)****
Team psychological safety			**1.32 (1.20–1.45)****
Constant	1.01	**0.34****	**0.00****
χ^2 (*df*)	16.96 (8)	153.16 (15)	688.43 (19)
Log likelihood	3798.11	3661.90	3126.64
Nagelkerke R^2	.01	.07	.29

Note. $N = 2{,}797$. Boldfaced values denote statistically significant predictors. CI = confidence interval; OHS = occupational health and safety; OPM-MU = Organizational Performance Metric–Monash University; *OR* = odds ratio; OVA = occupational violence and aggression.
*$p < .05$; **$p < .01$.

respondent had little impact on whether respondents would receive postincident support. Although respondents in the 36 to 45 year age group were less likely to receive postincident support than the 18 to 25 year age group, other demographic characteristics were not statistically significant predictors.

With respect to our research question regarding the relative impact of workplace type, OVA strategies and interventions, and the broader OHS environment, we found that overall it was the broader OHS environment (characterized by higher levels of leading indicators of OHS, prioritization of OHS, supervisor support for safety, and team psychological safety) that was the dominant contributor in predicting the likelihood of receiving postincident support. With regard to the workplace type variable, those working in general practice were twice as likely as those in public hospitals to receive postincident support. Having completed OVA training also increased the likelihood of receiving postincident support. Interestingly, the presence of an OVA prevention and management policy was not a statistically significant predictor of postincident support. While most workplaces did have a policy on OVA prevention and management in place, this outcome suggests that policy is only a first step towards effectively dealing with OVA and that policy must be supported and enacted by other organizational practices.

It is difficult to compare the present results with earlier research because, to our knowledge, there are few empirical studies that have examined incident support, and these studies did not examine the issue in detail. Scholars such as AbuAlRub and Al-Asmar (2011), Campbell (2011), and O'Connell et al. (2000) have indicated that organizational postincident support is important, but often lacking, for nurses who are more likely to receive informal sources of support from peers. Our study is consistent with this previous research in highlighting the importance of organizational-level support. However, we extend this research by showing that the likelihood

of workers receiving incident support arises from a supportive OHS environment, including the prioritization of OHS and greater levels of OHS leading indicators, supervisor support, and team psychological safety.

The present study supports the need for a greater emphasis on the OHS environment as facilitators of incident support. However, despite this and earlier research demonstrating the importance of both peer support (Purpora & Blegen, 2015; van Emmerik et al., 2007) and organizational support (Azar et al., 2016; De Puy et al., 2015; Leather et al., 1998; Schat & Frone, 2011) in managing the aftermath of OVA for workers, there is still a need for greater clarity on which drivers or workplace conditions facilitate the provision of incident support and how to effectively apply that support. It was beyond the scope of this study to conduct an in-depth examination of the types of incident support received by respondents, but examining the organizational factors that facilitate both formal and informal sources of support could be a fruitful avenue for future research.

There are some limitations in the present study, including the low response rate and the use of a cross-sectional design. However, the sample used in this study is large and demographically representative of the Australian nursing and healthcare profession, and a wave analysis showed no evidence of nonresponse bias. As this was a cross-sectional survey, we took several steps to reduce the problems associated with common-method variance, which included ensuring that the independent variables were presented in different sections of the survey from the dependent variable, varying response anchors for different subscales, and emphasizing to participants that their responses would be anonymous (Podsakoff, MacKenzie, & Podsakoff, 2012). Further, some research has indicated that individual personality characteristics might increase nurse vulnerability to OVA (Spector, Coulter, Stockwell, & Matz, 2007), and this would be an interesting addition to future studies.

Conclusions

We examined the relative contributions of workplace type, OVA strategies and interventions, and the broader OHS environment in terms of the likelihood that workers in the healthcare field would receive incident support following OVA. We found that the broader OHS environment was the dominant contributor to the likelihood of receiving incident support following OVA. While greater levels of training in management of OVA were important, it was the OHS environment factors (leading indicators of OHS, the prioritization of OHS, supervisor support for safety, team psychological safety) that were more important. The presence of policy for the prevention and management of OVA was not a significant predictor of incident support; however, this may be because policy alone is not sufficient to drive positive working conditions and that a greater emphasis on supportive organizational practices are required for policy to be effectively implemented.

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Clinical Resources

- Australian Nursing & Midwifery Federation. New guide for health services to create safe workplaces: https://www.anmfvic.asn.au/news-and-publications/news/2017/09/14/new-guide-for-health-services-to-create-safe-workplaces
- National Institute for Occupational Safety and Health. Occupational violence: https://www.cdc.gov/niosh/topics/violence/

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