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An investigation of post-incident support for healthcare workers experiencing occupational violence and aggression

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1. Executive Summary

The results presented in this report are part of a larger survey that was conducted with members of the Australian Nursing and Midwifery Federation (ANMF) (Victorian Branch) in April and May 2014 by a Monash University research team. The original survey contained questions about several aspects of occupational health and safety and the outcomes of that broader survey have been reported elsewhere.[1] The present report will focus on respondent perceptions of post-incident support following their experience of occupational violence and aggression (OVA).

1.1. Background

The healthcare workforce in Australia is a large and diverse workforce that spans many occupations. Nurses and midwives represent over half of all registered healthcare practitioners in Australia with the nursing profession being the largest single healthcare profession in Australia.[2, 3] A dominant concern for this group is their exposure to occupational violence and aggression (OVA), which has been found to be prevalent both globally[4] and in Australia.[5] Compared with workers in other industries, the level of work-related violence experienced by those employed in the nursing and healthcare workforce experience is among the highest.[6] The experience of OVA has been reported to have negative effects at multiple levels that include the individual, the organisation and society. A review by Lanctôt and Guay[7] described a range of personal consequences associated with OVA for healthcare workers that include physical, psychological, emotional, financial and social problems.

Occupational violence and aggression has been associated with common mental health issues such as stress,[8] anxiety[9] and depression[10] as well as post-traumatic stress disorder and burnout.[11] OVA has also been associated with physical health issues such as lower body musculoskeletal disorders.[12] In addition, Lanctôt and Guay's[7] review found that healthcare workers who experience OVA have reported reduced job satisfaction,[8, 13] increased intention to leave,[8] and reduced organisational commitment.[13]

At the organisation level the impact of OVA at work has been associated with decreased employee job performance[14] and productivity[15] along with increased absenteeism[16, 17] and turnover[18] and loss of reputation.[19] Nurses who have experienced OVA are more likely to have a reduced capacity to function in their workplace and difficulties in caring for their patients due to the disruptive influence of the aggressor.[20]

It is difficult to estimate the impact and costs at the broader societal level but tangible costs include the medical expenses connected with physical or psychological injury[19] and injury compensation costs.[19, 21] The loss of skilled workers who leave their job prematurely due to stress or incapacitation can include tangible costs such as government benefits as well as intangible costs with the loss of skills to their profession.[19]

Responses to OVA in the healthcare sector can be seen at government[22, 23] and union[24] levels. In Australia, the Victorian Government set up the *Violence in Healthcare Taskforce* to investigate how to reduce violence in Victorian hospitals. The report of the Taskforce places 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."[25, p3] Leadership and accountability are considered by the Taskforce to be critical in determining

such change. Addressing the recommendations of the Taskforce is an important and necessary step; however, there is relatively little information available about what responses are occurring at the workplace level with respect to worker support and follow-up of their experience of OVA.

Workplace strategies or interventions such as organisational support and peer support can reduce the impact of OVA on the psychological and work functioning of employees. Earlier research has shown that organisational support can reduce the negative impact of OVA on employee wellbeing,[26] job satisfaction[26] and organisational commitment[26, 27] and buffer the impact of OVA on stress and intention to leave in nurses.[28] Peer support has been reported to reduce the impact of OVA on job satisfaction.[29]

These earlier studies provide some evidence of the workplace practices that might be beneficial to workers. However in terms of post-incident support there appears to be very little research evidence on whether healthcare workers receive post-incident support or what kinds of support might be available. Given the scarcity of research in this area, the overall objective of this report was to examine the key barriers or challenges to receiving post-incident support following the experience of OVA. We examined this issue through the perceptions of Victorian healthcare workers and focused on whether these workers received post-incident support and why they believed they did not receive support. Their perceptions of why they did not receive support were examined at the societal, organisational, workgroup, and individual level.

This report addresses the following research questions:

1) Who is more likely to receive post-incident support?
2) What are the societal, organisational, workgroup, and individual reasons that healthcare workers do not receive post-incident support?

We also conducted post-hoc analysis on a small subset of comments where respondents offered greater detail, explaining that they did not receive post incident support because they did not seek out the support. The question we sought to answer here was:

3) Why do some healthcare workers not seek post-incident support?

1.2. Research method

ANMF (Victorian Branch) members were invited to participate in an online survey through April and May 2014. The survey targeted all registered members of the ANMF (Victorian Branch). Overall, 69,927 members had the opportunity to participate in the survey. Responses were received from 4,891 members: 3,273 registered nurses (67 percent), 1,055 enrolled nurses (22 percent), 407 midwives (8 percent) and 156 personal carers (3 percent). This resulted in a 7 percent response rate.

Occupational violence and aggression was experienced by a substantial proportion of the sample. Of the 4,891 respondents, 3,072 (67%) reported having experienced OVA at some time in the past 12 months. The respondents who reported that they had experienced OVA in the past 12 months (*n* = 3,072) were asked if they had received post-incident support and of these 1,728 (57%) respondents reported that they had not received support after an incident of OVA. It is this subset of 1,728 respondents who formed the sample for this report.

We used summary statistics to describe the characteristics of the sample and their exposure to OVA. We also examined the provision of post-incident support with respect to respondent and workplace characteristics.

The open-ended responses to the question “if post-incident support was not provided to you following the incident, why not?” were then subjected to a thematic analysis. It should be noted that respondents may have provided more than one reason for not receiving post-incident support so each reason was coded according to theme. We coded the comments according to four broad levels of analysis: societal, organisational, the workgroup, and the individual. The comments were further broken down into sub-themes within each of these four broad levels.

1.3. Key findings

The key findings from the post-incident support data are summarised below.

1) **Who is more likely to receive post-incident support?** There were few differences among those who received post-incident support by demographic group. Registered nurses and enrolled nurses were more likely to receive post-incident support compared to midwives and personal carers. Respondents employed in public hospitals, private hospitals and aged care facilities were less likely to receive post-incident support compared to those working in general practice, local government and community settings. However, no statistically significant differences were observed on the basis of age, workplace tenure or employment status (e.g., full-time versus part-time).

2) **What are the societal, organisational, workgroup, and individual reasons that healthcare workers do not receive post-incident support?** Analysis of comments by respondents who had experienced OVA regarding why they did not receive post-incident support were categorised into four broad categories: societal, organisational, workgroup, and individual. Most respondents indicated that the lack of post-incident support was due to factors associated with their workgroup context or factors specific to the individual.

   Respondents’ comments that identified reasons at the societal level primarily connected the experience of OVA in healthcare with trends that have resulted in OVA becoming a socially accepted part of the job for nurses and healthcare workers. Specifically, workers reported that OVA was influenced by societal problems that included a lack of civility, a sense of entitlement, patients being under the influence of drugs, and the level of violence in computer games normalising violence in general. Comments also reflected concerns that healthcare workers were not respected in society as professionals and that OVA in healthcare was becoming viewed as ‘normal’.

   Comments that identified reasons at the organisational level were more diverse but could be grouped into four sub-themes:

   - lack of prioritisation of staff health and safety;
   - lack of resources;
   - post-incident support was not available or not offered; and
   - OVA was seen as a high frequency event such that it was not possible to report or receive support for every incident.

These comments were dominated by the view that staff concerns were not taken seriously by management due to a lack of leadership commitment to OHS, and that the needs of patients and their relatives were prioritised over OHS. There was also the perception that there were not enough resources available to report OVA or access support. More specific reasons included: respondents described the RiskMan reporting system as too cumbersome; staff work outside of standard office hours do not have ready access to post-incident support; or respondents were too busy and unable to take time away from their patients to report OVA or access support.

Comments focused on the workgroup level were coded into five sub-themes:

- managers or supervisors did not care/were not supportive;
- a culture of fear and blame;
- management conflicts;
- there was no follow up; and
- managers or supervisors saw OVA as 'part of the job'.

Respondents' comments indicated that they believed management did not take OVA seriously, did not care, or did not respond to staff concerns effectively. There were respondents who also felt that there was a culture of fear and blame in their workgroup so they did not wish to report OVA. Some respondents believed that managers and supervisors were compromised in their reactions to staff experiences of OVA due to conflicts of interest. A perceived lack of management follow-up on reports of OVA was also seen as a problem by those who reported incidents. These respondents indicated that both formal reports such as RiskMan and informal discussions with management were not acted on. In some workgroups, such as emergency departments or aged care facilities, respondents believed there was a culture of acceptance that OVA was 'just part of the job.'

At the individual level, reasons for not receiving post incident support were coded into four sub-themes:

- did not report OVA and/or did not request support;
- felt post-incident support was not required;
- lack of status; and
- don't know.

There were several reasons for why respondents did not report or request post-incident support. The most common reasons were that either they believed that nothing would be done about the incident or they did not feel they needed support. This situation was further exacerbated for those who saw themselves as lacking in status, such as enrolled nurses and agency staff. A small subset of respondents reported that they did not know why they did not receive post-incident support.

3) **Why do some healthcare workers not seek post-incident support?** As noted in the comments addressing the individual level, there was a subset of respondents who did not report incidents or request post-incident support (*n* = 223). It was beyond the scope of the broader survey to delve into why respondents did not request or need post-incident support so there was no direct question about this. While nearly half of this subset of respondents did not give a reason for not reporting or requesting post-incident support, 133 respondents did give more detailed answers. These respondents indicated that they did not report or request post-incident support due to: being able to cope, being too busy, conflict with managers, the incident was minor and they were not injured, OVA was seen as part of the job, or because the incident was resolved at the time.

1.4. Recommendations

Recent reports by the Victorian Auditor General's Office[23, 30] as well as the 2016 Violence in Healthcare Taskforce report[25] indicate collaborative and ongoing efforts to address OVA. We note that the Taskforce has identified a set of recommendations to deal with OVA in healthcare, which included the recommendation to "develop and implement a simplified reporting system". We endorse the recommendations of the Taskforce. We also note that the *2013 Occupational violence incident response guide for employers*[31] offers a comprehensive framework of advice and guidance.

The data analysed for this report show that some employment settings within healthcare, such as emergency departments, mental health facilities and aged care facilities, present distinctive challenges for the reporting of OVA and represent priority areas for post-incident support. In any context, there are numerous issues to be resolved to ensure the risk of OVA is reduced and staff have the capacity to access support where needed.

Our recommendations are intended to offer guidance for practical actions that could be introduced at workplace and organisational levels. Overall, this research has contributed to a better understanding of OVA in healthcare and factors related to reporting and post-incident support. There is further value in research that evaluates real-world implementation of interventions aligned with our recommendations.

We recommend addressing workplace barriers and challenges to reduce and prevent:

1) incivility within the work environment;
2) a propensity to blame the victim; and
3) the view of OVA as being 'just part of the job' for healthcare workers.

This could be facilitated by promoting: respect for employees; reinforcing zero tolerance for violence (e.g., ANMF (Victorian Branch) 10 point plan to end violence and aggression); and formal and informal support mechanisms that allow employees to debrief following incidents of OVA.

With respect to organisational practices we recommend:

4) designing and implementing a process of accountability for leaders, managers and supervisors with respect to OVA prevention, management and response;
5) training in debriefing for supervisors and co-workers who find themselves assisting an employee who has experienced OVA;

6) prioritising occupational health and safety at the same level as patient safety;

7) ensuring there is a simplified formal process through which OVA can be reported and workers can seek support as required; and

8) creating opportunities for staff to report OVA and request support within work time.

1.5. Conclusion

Overall, this research has contributed to a better understanding of the barriers or challenges Victorian healthcare workers face with respect to post-incident support following the experience of OVA. By investigating the barriers and challenges related to the reporting of OVA, this report builds on the previous efforts and identifies areas for the development and implementation of policy, workplace-based strategies, evaluation and research focused on OVA.

2. Introduction

The healthcare workforce in Australia is a large and diverse workforce that spans many occupations. Nurses and midwives represent over half of all registered healthcare practitioners in Australia with the nursing profession being the largest single healthcare profession in Australia.[2, 3] A dominant concern for this group is their exposure to occupational violence and aggression (OVA), which has been found to be prevalent both globally[4] and in Australia.[5] Compared with workers in other industries, the level of work-related violence experienced by those employed in the nursing and healthcare workforce experience is among the highest.[6] The experience of OVA has been reported to have negative effects at multiple levels that include the individual, the organisation and society. A review by Lanctôt and Guay[7] described a range of personal consequences associated with OVA for healthcare workers that include physical, psychological, emotional, financial and social problems.

Occupational violence and aggression has been associated with common mental health issues such as stress,[8] anxiety[9] and depression[10] as well as post-traumatic stress disorder and burnout.[11] OVA has also been associated with physical health issues such as lower body musculoskeletal disorders.[12] In addition, Lanctôt and Guay's[7] review found that healthcare workers who experience OVA have reported reduced job satisfaction,[8, 13] increased intention to leave,[8] and reduced organisational commitment.[13]

At the organisation level the impact of OVA at work has been associated with decreased employee job performance[14] and productivity[15] along with increased absenteeism[16, 17] and turnover[18] and loss of reputation.[19] Nurses who have experienced OVA are more likely to have a reduced capacity to function in their workplace and difficulties in caring for their patients due to the disruptive influence of the aggressor.[20]

It is difficult to estimate the impact and costs at the broader societal level although tangible costs include the medical expenses connected with physical or psychological injury[19] and injury compensation costs.[19, 21] The loss of skilled workers who leave their job prematurely due to stress or incapacitation can include tangible costs such as government benefits as well as intangible costs with the loss of skills to their profession.[19]

2.1. Background

Responses to OVA in the healthcare sector can be seen at government[22, 23] and union[24] levels. In Australia, the Victorian Government set up the *Violence in Healthcare Taskforce* to investigate how to reduce violence in Victorian hospitals. The Taskforce report places 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."[25, p3] Leadership and accountability are considered by the Taskforce to be critical in determining such change. Addressing the recommendations of the taskforce is an important and necessary step; however, at this stage it is not clear what responses are occurring at the workplace level with respect to worker support and follow-up of their experience of OVA.

Workplace strategies or interventions such as organisational support and peer support can reduce the impact of OVA or unsafe work environments on the psychological and work functioning of employees. Earlier research has shown that organisational support can reduce the impact of OVA on employee wellbeing,[26] job satisfaction[26] and organisational

commitment[26, 27] and buffer the negative impact of OVA on stress and intention to leave in nurses.[28] Peer support has been reported to reduce the impact of OVA on job satisfaction.[29]

These earlier studies provide some evidence of the workplace practices that might be beneficial to workers. However in terms of post-incident support there appears to be very little research evidence. Indirect evidence for the impact of post-incident support comes from studies of OVA in healthcare where nurses reported on the sources of post-incident support, which came from both informal sources such as peers, family and friends[17] and formal sources such as the employer or supervisor.[32] A study by Campbell[33] using semi-structured interviews with nurses investigated the kind of post-incident support they received. Campbell reported that the major source of post-incident support was peer support rather than support from the organisation in general. Campbell emphasised that broader organisational support was considered important to nurses but that this did not necessarily occur because nurses' capacity to cope with OVA was not well-understood by management. Furthermore, another study has shown that nurses are sometimes unaware of the post-incident support that might available to them.[17]

One study that has interesting implications for the provision of post-incident support was conducted by De Puy and colleagues.[34] The authors of this study investigated the influence of several sources of support (i.e., family and friends, colleagues, 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 organisational support following the experience of OVA can increase the impact severity of OVA. The interesting outcome of the study was that it was only support from the employer that significantly reduced the impact severity of OVA and consequently, improved the possibility of preventing negative outcomes for the target. There was no statistically significant effect of support from family, friends or colleagues on the impact severity of OVA.

2.2. Research questions

Given the scarcity of research in the area of post-incident support, the overall objective of this report was to examine the key barriers or challenges to receiving post-incident support following the experience of OVA. We examined this issue through the perceptions of Victorian healthcare workers and focused on whether these workers received post-incident support and why they believed they did not receive support. Their perceptions of why they did not receive support were examined at the societal, organisational, workgroup, and individual level.

This report addresses the following research questions:

1) Who is more likely to receive post-incident support?
2) What are the societal, organisational, workgroup, and individual reasons that healthcare workers do not receive post-incident support?

We also conducted post-hoc analysis on a small subset of comments where respondents offered greater detail, explaining that they did not receive post incident support because they did not seek out the support. The question we sought to answer here was:

3) Why do some healthcare workers not seek post-incident support?

3. Methods

3.1. Sample and procedure

This report is based on data extracted from a larger survey conducted with the members of the Australian Nursing and Midwifery Federation (ANMF: Victorian Branch).[1] Members of the ANMF were invited to participate in an occupational health and safety (OHS) survey during April and May 2014. The survey was conducted online and targeted all registered members of the ANMF (Victorian Branch). While the original survey was contained questions about several aspects of occupational health and safety, this report will focus on post-incident support following an experience of OVA.

Overall, 69,927 members had the opportunity to participate in the survey; responses were received from 4,891 members. This resulted in a 7 percent response rate. As shown in Figure 1 below the majority of respondents were registered nurses.

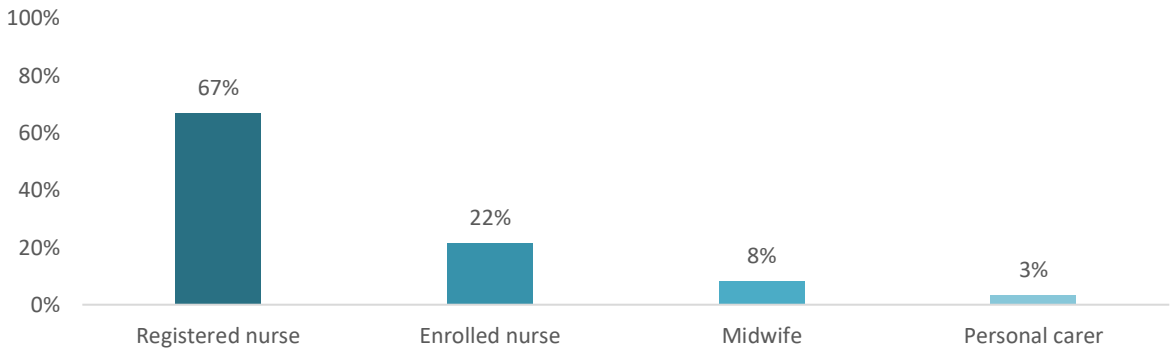

Figure 1: Member type

Nearly all respondents were female and generally 55 years of age or less, with the largest percentage of respondents being in the 46 to 55 years age group.

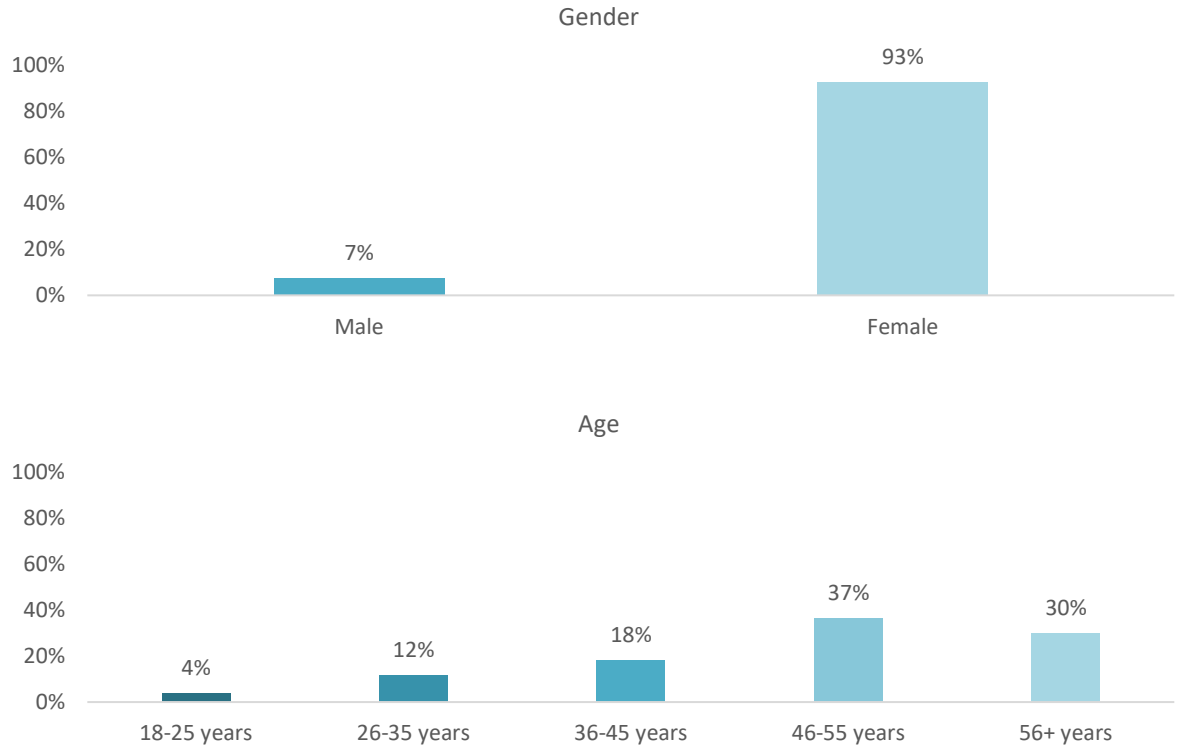

Figure 2: Personal characteristics of the sample

With regard to work characteristics, more than half of the sample was employed in a public hospital and had been employed by their current employer for 10 years or less. More than half of the respondents worked part-time and only one quarter of respondents were employed in a full-time capacity.

Figure 3: Work characteristics of the sample

All respondents were asked to answer the following broad question:

- Have you experienced occupational violence and / or aggression at your workplace during the last 12 months? Respondents were asked to use one of following response options: 1 Yes daily, 2 Yes weekly, 3 Yes monthly, 4 Yes a few times, 5 No never. For the purpose of this study, response options were collapsed into yes (1 to 4) and no (5).

Respondents who responded that they had been exposed to OVA in the past 12 months, were then asked to answer two additional questions:

- was post-incident support provided to you following the incident? (yes, no);
- if post-incident support was not provided to you following the incident, why not?

Respondents gave an open answer to the second question.

3.2. Analysis

We used summary statistics to describe the characteristics of the sample and their exposure to OVA. We also examined the provision of post-incident support with respect to respondent and workplace characteristics.

The open-ended responses to the question “if post-incident support was not provided to you following the incident, why not?” were then subjected to a thematic analysis. It should be noted that respondents may have provided more than one reason for not receiving post-incident support so each reason was coded according to theme. Two researchers manually coded the comments according to four broad levels: societal, organisational, the workgroup and the individual. The comments were further broken down into sub-themes within each of these four broad levels.

4. Results

4.1. Frequency and source of OVA

Occupational violence and aggression was experienced by a substantial proportion of the sample. Of the 4,891 respondents participating in the survey, 3,072 (67%) reported having experienced OVA at some time in the past 12 months. Figure 4 below shows the frequency of OVA in the sample. For details of the extent and source of OVA experienced by nursing and healthcare professionals, see our previous report[1] and publication.[35]

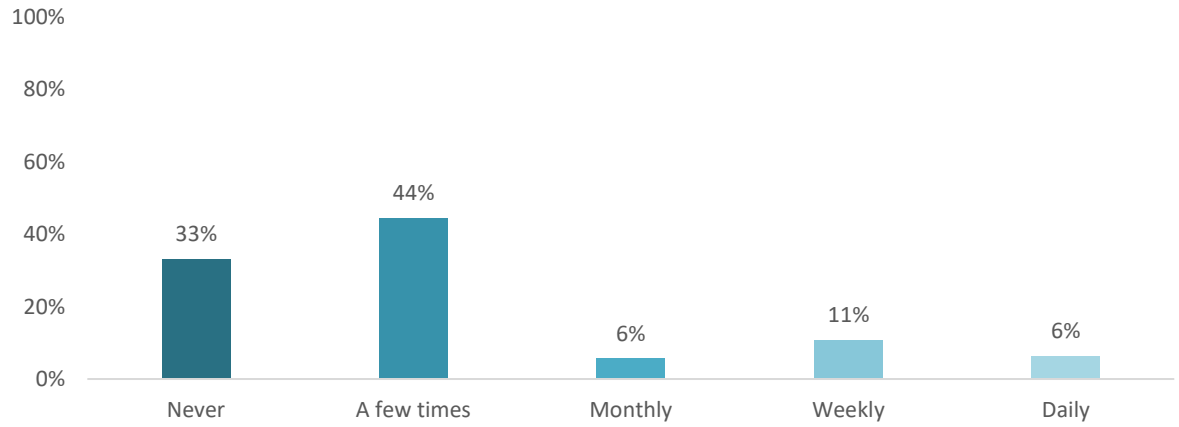

Figure 4: Frequency of occupational violence & aggression

Figure 5 below shows the distribution of OVA by source.[1] Of the 3,072 respondents who had experienced OVA, most respondents reported that the experience of OVA was largely from patients followed by relatives of patients, visitors of patients, managers and other colleagues and members of the public.

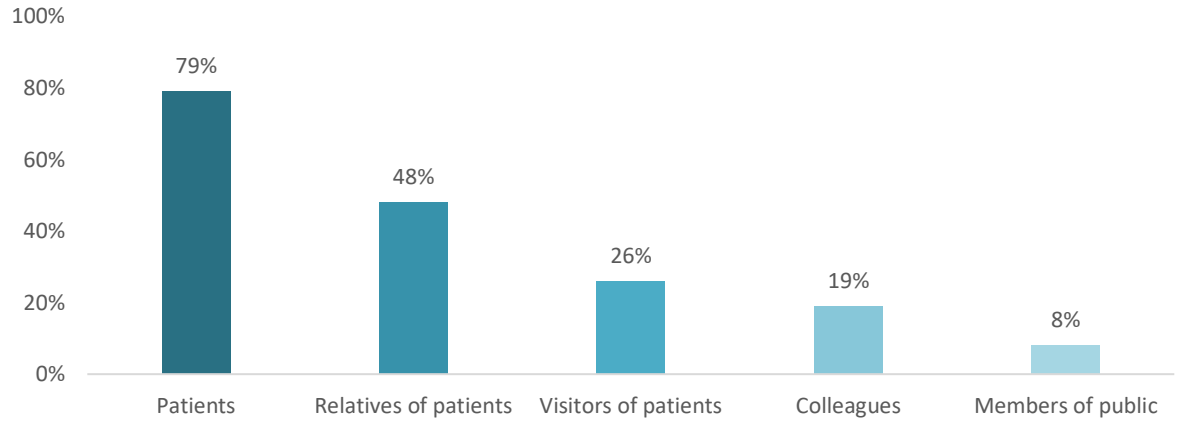

Figure 5: Sources of occupational violence & aggression

[1] Note that percentages do not add to 100 because respondents were allowed to select more than one source where appropriate.

4.2. Who is more likely to receive post-incident support?

The respondents who reported that they had experienced OVA in the past 12 months were asked if they had received post-incident support and 1,728 (57%) respondents reported that they had not received support after an incident of OVA. The charts below compare respondents by personal and work characteristics.

Figure 6 below shows that registered nurses and enrolled nurses were more likely to report that they had received post-incident support compared to midwives and personal carers. This difference for support by job role was statistically significant.

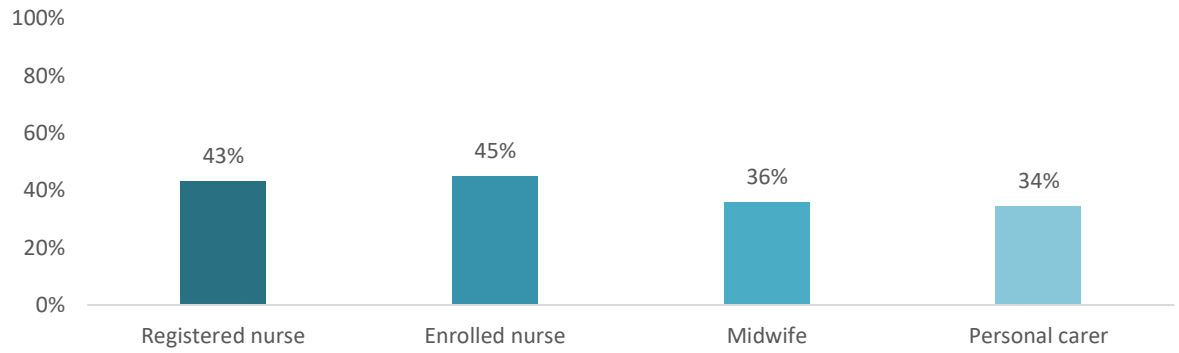

Figure 6: Post-incident support by job role

Figure 7 below shows that there was no statistically significant difference between males and females with regard to their likelihood of receiving post-incident support.

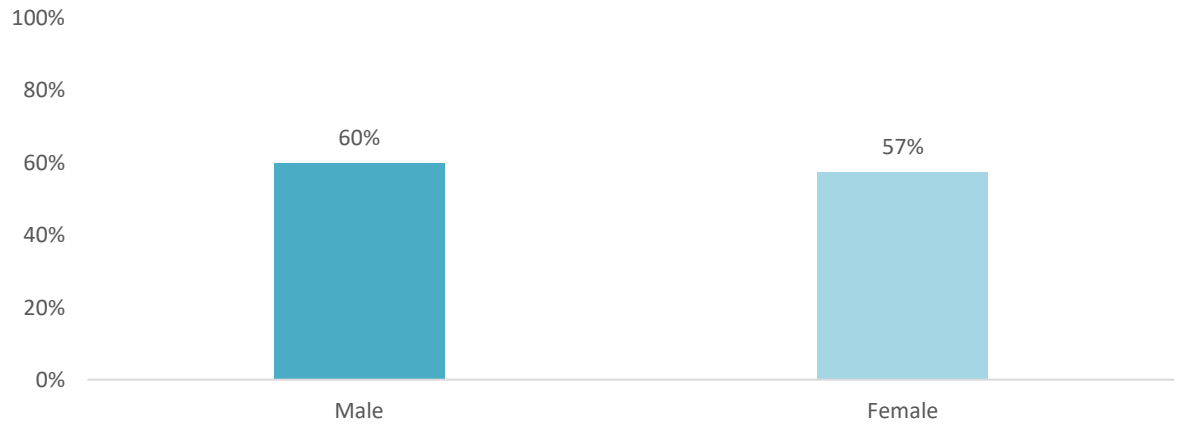

Figure 7: Post-incident support by gender

Figure 8 below shows slight differences between age groups with regard to receiving post-incident support. However, these differences in age were not statistically significant.

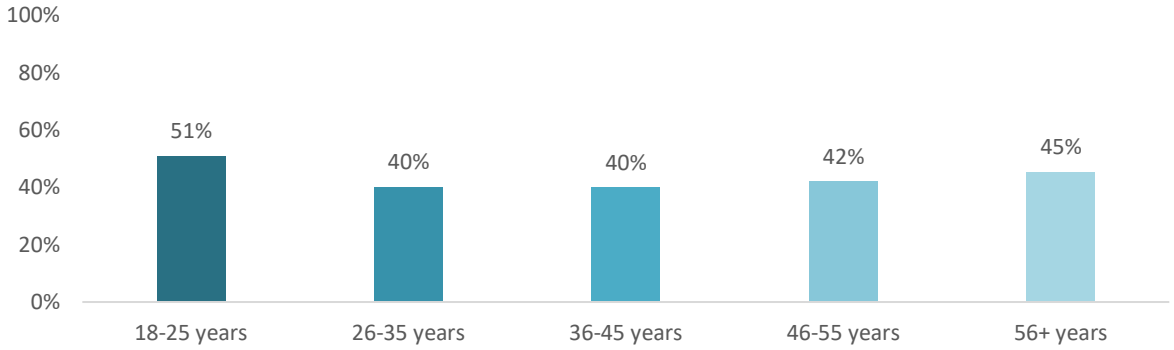

Figure 8: Post-incident support by age

Figure 9 below shows that respondents who worked in general practice, local government and community settings were more likely to receive post-incident support compared to respondents working in public and private hospitals or aged care facilities. This difference for support by workplace was statistically significant.

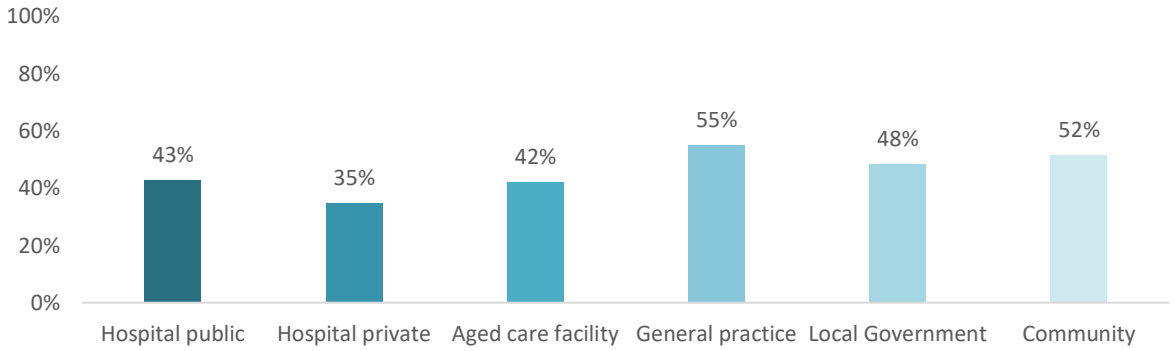

Figure 9: Post-incident support by workplace type

Figure 10 below shows some slight differences in receipt of post-incident support between respondents with regard to the length of time they had been employed in their workplace. However, these slight differences were not statistically significant.

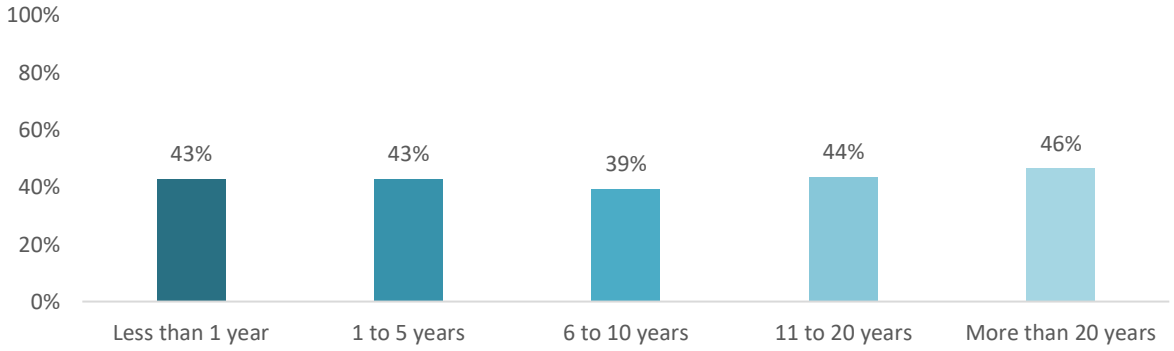

Figure 10: Post-incident support by workplace tenure

Figure 11 below shows no statistically significant difference with regard to receipt of post-incident support between respondents who worked full-time compared to those who worked part-time or casual hours.

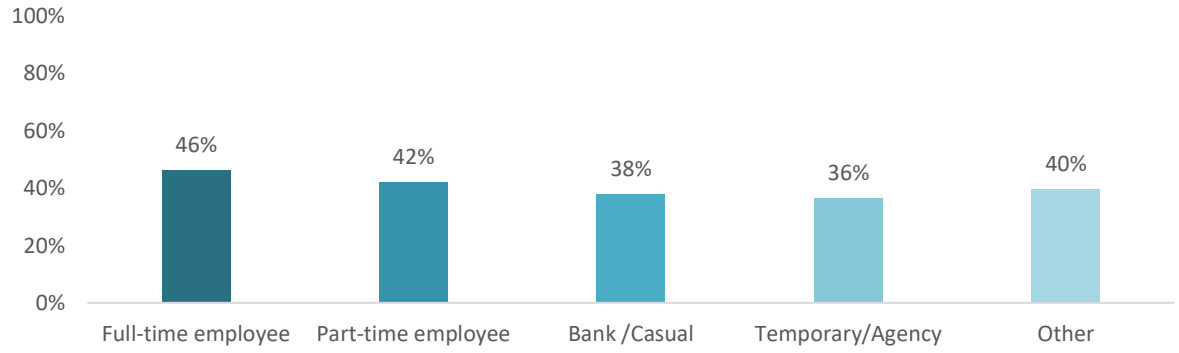

Figure 11: Post-incident support by employee status

4.3. What are the societal, organisational, workgroup, and individual reasons that healthcare workers do not receive post-incident support?

The respondents who indicated that they did not receive post-incident support (*n* = 1,728) were asked to comment on their perceptions of why they did not receive post-incident support. Within this subset of the sample, 1,425 (83%) respondents generated 1,746 comments[2] that were categorised into four broad themes. These themes were: societal, organisational, workgroup and individual levels. Figure 12 below displays the percentage of comments allocated to each theme. Most respondents indicated that the lack of post-incident support was due to factors associated with their workgroup context or factors specific to the individual.

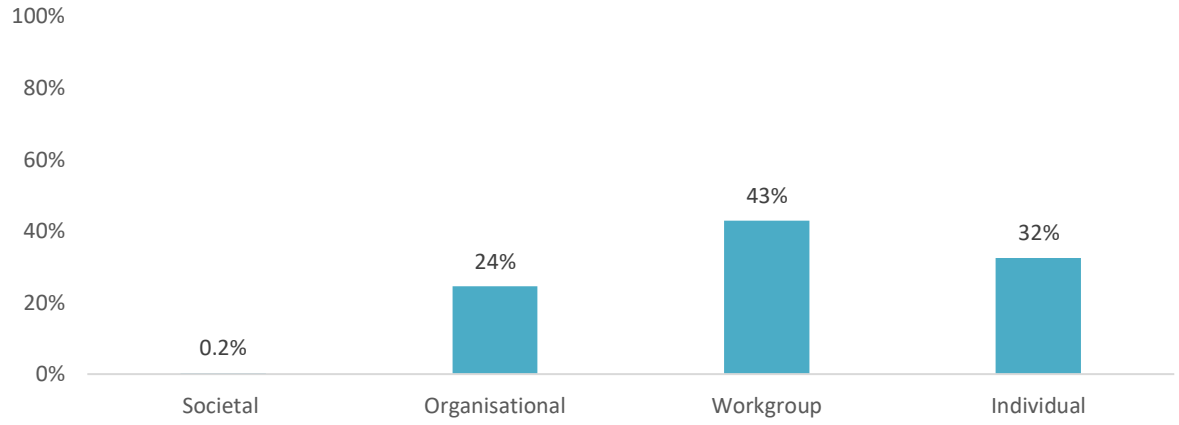

Figure 12: Reasons for lack of post-incident support

[2] Note that there are more comments than respondents because some respondents offered more than one reason for why they had not received post-incident support.

4.3.1. Societal level

Only four comments were categorised at the societal level. These comments primarily connected the experience of OVA in healthcare with trends that have resulted in OVA becoming a socially accepted part of the job for nurses and healthcare workers. Specifically, worker comments that noted OVA as part of the job were influenced by perceptions of problems within society that included a lack of civility, a sense of entitlement, patients being under the influence of drugs and the level of violence in computer games normalising violence in general. Comments also reflected concerns that healthcare workers were not respected in society as professionals and that OVA in healthcare was becoming viewed as 'normal'.

> *Just what a nurse has to put up with [these] days. People are rude, people feel entitled. There are more problems associated with substance abuse. Violence is glorified in computer games etc. The general public have lowered forms of respect [for] healthcare providers.* ***– Registered nurse, public hospital.***
>
> *Part of the work we do - labour ward, angry outbursts by partners, dealing with parents of sick babies with social/drug/child welfare issues.* ***– Midwife, public hospital.***
>
> *Verbal aggression and occasionally physical aggression towards nursing staff is a cultural norm and an expected occupational condition.* ***– Enrolled nurse, public hospital.***
>
> *It isn't always drug/psych related issues with patients, on many occasions it is private patients that think that it is a hotel and measure their care not on a professional level where their needs are met but what size room they have etc or if the hospital has promised them conditions that cannot be met if the rooms are full, and they are prepared to lie, particularly the educated ones. Our hospital is both private and public. Generally the public are becoming more spoilt.* ***– Midwife, public hospital.***

4.3.2. Organisational level

Comments addressing organisational level factors (*n* = 425) that were perceived by respondents to lead to a lack of post-incident support fell into four sub-themes: lack of prioritisation of occupational health and safety, lack of resources; post-incident support was not available; post-incident support was not offered; and OVA was seen as a high frequency event where OVA occurs on such a regular basis that they do not have time to report it. Figure 13 below displays the percentage of comments allocated to each category. More than half of the respondents simply stated that the lack of post-incident support was because it was not offered or indicated that there was a lack of prioritisation of occupational health and safety.

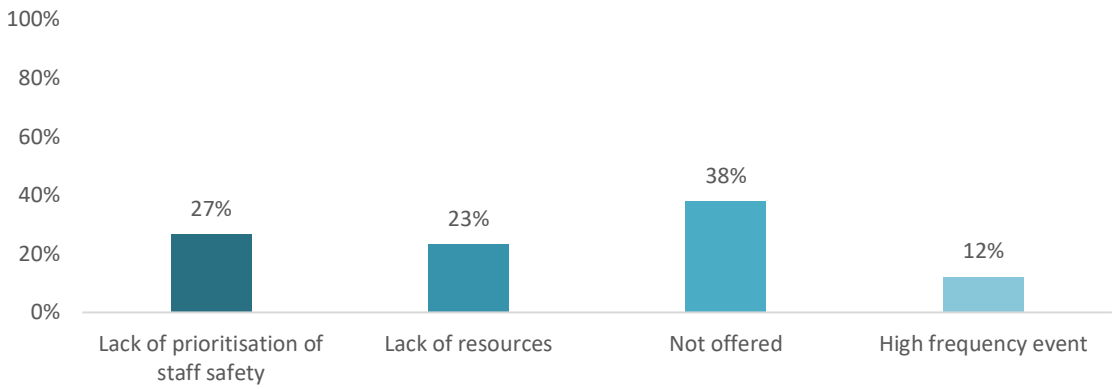

Figure 13: Perceptions of lack of support due to organisational factors

Lack of prioritisation of occupational health and safety. Some of the comments indicated that respondents felt their concerns were not taken seriously. There were also suggestions that patient safety was more important than staff health and safety.

Management are not supportive of their staff. ***– Enrolled nurse, community.***

Good question, why not indeed. A culture that does not embrace 'post incident support' perhaps. ***– Registered nurse, public hospital.***

Very little value is placed on supporting staff when an incident occurs, the emphasis is on the patient or others. ***– Registered nurse, community.***

Clearly not prioritised as important. Taken as "part of the job." ***– Registered nurse, public hospital.***

I do not consider management have any concept of the personal impact this has on their staff and so see it as a very low priority. ***– Enrolled nurse, public hospital.***

Not a WorkCover medical certificate - therefore don't have to take responsibility. ***– Enrolled nurse, general practice.***

Not taken as important by hospital, they are only concerned if it involves WorkCover. ***– Enrolled nurse, public hospital.***

Spoke to my manager but basically got a pat on the back and told not to worry about it. ***– Registered nurse, private hospital.***

No manager support as "patient /client is always right." ***– Midwife, private hospital.***

It is important to keep family members happy as funding is important. ***– Enrolled nurse, aged care facility.***

Management always side with the client and brutally criticize and condemn staff when hearing their case. ***– Midwife, private hospital.***

It was more important to keep family/guests happy rather than workers. ***– Enrolled nurse, aged care facility.***

NUM [Nurse Unit Manager] did not want to upset relatives, panders to their every whim. ***– Enrolled nurse, aged care facility.***

Patient aggression is not managed well in my work place, as I work for a private for profit hospital. Management are incapable of addressing patient aggression with the patients and their consulting doctor for fear of affecting profit. Aggressive patients are left to the nursing staff to deal with. ***– Registered nurse, private hospital.***

Management is more concerned about the needs of patients and relatives, rather than supporting their nursing staff. ***– Registered nurse, public hospital.***

It seems to be that putting in an incident report is deemed as support. The report is far more important than the actual repeated physical and verbal abuse we contend with on a daily/hourly basis. Increased funding comes from difficult residents. Therefore the priority is to get it down in writing so that the claim for extra funding can be supported. ***– Enrolled nurse, aged care facility.***

It was deemed that this aggression is "part of the job" and support is not necessary. I was basically told to toughen up. ***– Registered nurse, private hospital.***

Because it is an everyday occurrence and we are all used to it and it just goes with the job. ***– Enrolled nurse, public hospital.***

Happens to everyone, usual to experience agitated patients/ families/visitors at least once a week. ***– Enrolled nurse, private hospital.***

Lack of resources. Comments in this sub-theme indicated that barriers to achieving post-incident support were related to system issues and also time factors within the respondent's workplace.

System issues included comments about the practical complexity of the system used to report OVA, the lack of support for staff when working outside normal working hours, poor communication between management and staff, and a lack of confidentiality that discouraged reporting and seeking support.

The reporting of such incidents takes forever we as practical nurses are very stressed with the inundation of paperwork, computer work … that where we can prioritise, our normal nursing work always takes precedence. ***– Registered nurse, public hospital.***

Too hard to access. Need to go through a coordinator who will determine your need. ***– Registered nurse, public hospital.***

The complexity of RISKMAN data entry requirements makes reporting time prohibitive, and I am IT savvy and have been OHS rep. ***– Registered nurse, public hospital.***

Night staff don't get much support offered. ***– Enrolled nurse, public hospital.***

There is nothing in place during out of office hours, especially when working afternoon shift. ***– Enrolled nurse, aged care facility.***

As an agency nurse, you are often working alone and in charge of an ACF. There usually isn't anyone to report to or talk to about such an incident until night shift start. ***– Enrolled nurse, aged care facility.***

No communication between management and staff. ***– Registered nurse, aged care facility.***

Too much effort to report and no or minimal feedback / support. Cannot report anonymously any more. ***– Registered nurse, public hospital.***

Incidents often occur after-hours and on weekend shifts when post-support is not readily available. These shifts are staffed with skeleton staff and one does not have time to stop work to seek immediate support following an upsetting incident. You are not given time during your shift to complete a riskman and you are expected to stay back after your shift to complete one. A riskman generally takes 20 mins to complete and after working anywhere between 9.5 - 15hrs straight … you just want to go home. Supervisors are generally not readily available on your next shift to debrief with and as a worker on the floor, you need to be replaced to leave your patient and see your supervisor to debrief. This just does not happen unfortunately. Everything is about money and meeting targets. ***– Registered nurse, public hospital.***

As well as concerns about the systemic barriers to post-incident support, being too busy was a dominant concern.

No time for anything else than immediate patient care. ***– Registered nurse, public hospital.***

In the area of aged care there is not enough staff at any level. Everyone works hard just to provide basic needs to residents. ***– Registered nurse, aged care facility.***

Tends to be accepted as part of the job, unless it is an exceptional circumstances and even that you are not provided the time to attend!! ***– Registered nurse, public hospital.***

Time constraints main reason, in order to organise a de-brief you need time to come off the floor with all people involved and this is often not available in the emergency department. ***– Registered nurse, public hospital.***

Support not offered. Some respondents simply said that post-incident support was not offered but did not elaborate on why post-incident support was not offered in their workplaces. For those who did elaborate, their explanation of an absence of support included de-sensitisation to the increased regularity of OVA incidents,[3] organisational culture, and the need for the OVA incident to be considered severe enough to warrant support. Other respondents stated they were unsure of why the support was not offered.

It is an aged psychiatry facility where residents are often aggressive. Physical aggression from residents towards staff is a regular occurrence. No support is usually provided. ***– Registered nurse, aged care facility.***

Not part of the culture unless there is a major incident. ***– Registered nurse, public hospital.***

Not given because you are just supposed to cope in the wing you work in and use. Not offered unless visibly affected, though I personally recommend to staff the peer support network but confidentiality is an issue. ***– Registered nurse, public hospital.***

[3] Note that this desensitisation to incidents of OVA as part of the job emerges as a theme in later coding connected with specific levels of seniority and workplaces.

Not given because you are just supposed to cope in the wing you work in and use distraction actions. ***– Personal carer, aged care facility.***

This kind of aggression is considered routine in our area. You would have to request this, it would not be offered. ***– Registered nurse, public hospital.***

Managers and Supervisors do not give the impression that they consider it important - and do not offer it. ***– Registered nurse, public hospital.***

It is probably available but not directly offered. ***– Registered nurse, public hospital.***

That's never been offered to me during my time with my employer. ***– Enrolled nurse, public hospital.***

Not usual to be provided with support. ***– Registered nurse, community.***

Incident report was submitted and management asked if we are okay and that is it. I don't consider this to be support. No offer of staff care, sometimes staff involved in incidents don't even see anyone from management. ***– Registered nurse, aged care facility.***

The lack of availability of post-incident support was also noted and was primarily attributed to an absence of policy or process that could enable workers to seek support following an incident.

No specific policies in place to ensure this occurred. Practice manager rarely available for discussion. ***– Registered nurse, general practice.***

Our hospital does not believe in debriefing any more - it did in the past but they say "the literature" states it causes more harm than good. ***– Registered nurse, community.***.

There is no policy that provides this service for staff. It's not a common practice for the organization to offer such support. Staff seek own support from doctors, counsellors and psychologist. ***– Registered nurse, aged care facility.***

It is not provided by the hospital to anyone following threats and physical violence. ***– Registered nurse, public hospital.***

I was not listened to, no procedural policies to follow, management didn't care. ***– Registered nurse, general practice.***

No official support process. Informal support from coworkers and sometimes nurse in charge of shift. ***– Registered nurse, public hospital.***

No real system in place other than casual debriefing. ***– Registered nurse, general practice.***

High frequency event. OVA was seen as a high-frequency event by some respondents. Respondents reported that OVA occurs on such a regular basis that they do not have time to report it. This lack of time to report would have impeded their capacity to seek post-incident support.

Aggressive incidents occur so commonly that reporting of each incident would occupy so much time little other work would get done. ***– Registered nurse, public hospital.***

Regular occurrence, we would be constantly getting support if they did give us post-incident support. ***– Registered nurse, public hospital.***

Incidents occur frequently in the emergency department so would be impossible to provide support for every act of aggression ED nurses/staff are subjected to. ***– Registered nurse, public hospital.***

Don't ask for it [post-incident support] as it's such a frequent event. ***– Registered nurse, public hospital.***

Made to feel this was not an unusual event and to move on to next task or "we will never get off on time." ***– Enrolled nurse, public hospital.***

It can be a regular occurrence with some patients and I do not take it personally. ***– Registered nurse, public hospital.***

It happens too often in the workplace that it has become an acceptable risk. ***– Registered nurse, public hospital.***

This is so common that its regarded as part of the job description. ***– Enrolled nurse, public hospital.***

It is a regular occurrence to be abused and threatened during work hours. ***– Registered nurse, public hospital.***

It happens too often, almost a "normal" part of my job. ***– Midwife, private hospital.***

I work with people who are often substance affected and/or suffering from severe mental illness. My entire day would be spent completing incident reports If I documented every instance of aggressive threatening or abusive behaviour. ***– Registered nurse, community.***

Happens too often. We would be having counselling more time than working. ***– Registered nurse, public hospital.***

4.3.3. Workgroup level

Comments addressing workgroup factors (*n* = 748) that were perceived by respondents to lead to a lack of post-incident support fell into five sub-themes: their manager or supervisor did not care or was not supportive; a culture of fear and blame; conflict of interest for their manager or supervisor; no follow up; and the manager or supervisor seeing OVA as being 'just part of the job'.

Figure 14 below displays the percentage of comments allocated to each category for the workgroup level. Most respondents indicated that the lack of post-incident support was due to OVA being a common experience and viewed as 'part of the job'. Respondents also indicated that they did not request post-incident support because of a perceived lack of support or follow-up from management. They also reported a fear that they might not be seen as competent or that they would be blamed for experiencing OVA.

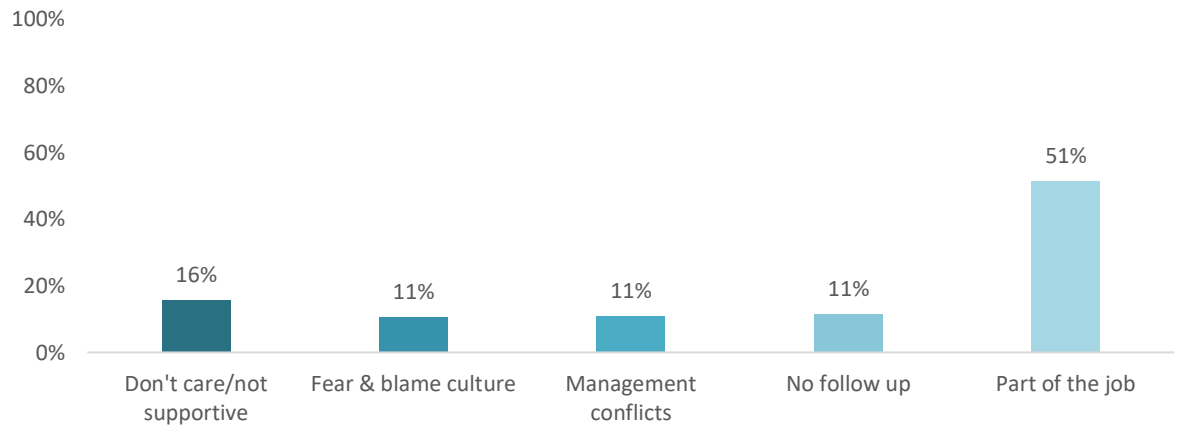

Figure 14: Perceptions of lack of support due to workgroup factors

Manager or supervisor did not care/was not supportive. Some respondents reported that they believed they did not receive post-incident support following OVA because managers and supervisors were not supportive or did not care about the impact of OVA on their staff. These comments reflected the actions (or inaction) by individual managers or supervisors and may not be reflective of or aligned with general organisational policies.

My employer has always neglected the staff and has never offered this service. ***– Enrolled nurse, general practice.***

Manager refuses to believe it is stressful or plays on the staff, as with this week staff member kicked. He spoke with the staff and scared them into retracting the incident report and a statutory declaration. So head office isn't aware of anything happening. ***– Enrolled nurse, aged care facility.***

It's just become almost acceptable behaviour, when I stop and think about how our team is treated by management, when we have spoken up, nothing is done, so we just continue on. ***– Registered nurse, public hospital.***

Management didn't appear to be concerned at all even though I spoke to the facility manager about it. It appears to be the preference of my facility manager to just sweep things under the carpet. ***– Enrolled nurse, aged care facility.***

Unit managers listen but do not put into practice what has been discussed. Some ANUMs are not supportive with proper work practices and are very argumentative. ***– Enrolled nurse, public hospital.***

I have no idea! I actually had to push for the incident to be reported to the police – the EDON was not concerned – the person involved was jailed for 4 months for assault!! ***– Registered nurse, public hospital.***

One resident is often verbally and physically aggressive. Staff were told not to put in Riskman's and to toughen up. ***– Enrolled nurse, aged care facility.***

Lack of support from management, they minimise the event or disregard it. ***– Enrolled nurse, aged care facility.***

Had a group discussion and told to just get over it. Nothing can be done. ***– Enrolled nurse, public hospital.***

Management thought I was imagining the incident/harassment. ***– Registered nurse, private hospital.***

A culture of fear and blame. Fear of blame or fear of consequences was cited as a reason for not reporting an incident or not receiving post-incident support. Some respondents stated that they were likely to be blamed for violent or aggressive incidents at work.

It wasn't reported and if it was it is always the nurse's fault that they did not manage the situation better. The manager has no sympathy or empathy for any victims. ***– Midwife, local government.***

Because those in charge don't provide support unless you ask for it and when you do it appears to be an effort. Then they want to know what you did to cause it. It feels like it's all your fault. ***– Registered nurse, public hospital.***

If there is an incident, the staff are always to blame. We are all supposed to know how to avoid any incident, regardless of time of day, lack of staff, more than one incident happening at the same time, lack of time to do both resident care and compulsory computer work. I could go on for pages! What is "post – incident support"? Even when I've been injured stopping residents from injuring other residents or staff – I'm still to blame for not handling the situation correctly. ***– Registered nurse, aged care facility.***

… patient in a wheelchair had the habit of bailing staff up against a wall and ramming them, it was reported to the Nurse Unit Manager and she replied "you shouldn't put yourself in that position." ***– Enrolled nurse, aged care facility.***

Human resources and management said it must have been my fault so not willing to take the other person to task when she almost physically assaulted me during a verbal confrontation instigated by her. ***– Midwife, public hospital.***

Entrenched culture of blame denial & neglect. ***– Registered nurse, public hospital.***

While there is a zero tolerance policy – it never seems to be enforced. Staff are always made out to be at fault. ***– Registered nurse, public hospital.***

Conflicts with managers or supervisors. Respondents reported a lack of post-incident support when incidents of OVA originated from management. Respondents also reported situations where managers did not provide support due to their conflicted loyalties to other senior managers or specialist doctors. These comments reflected the actions (or inaction) by individual managers or supervisors and may not be reflective of or aligned with general organisational policies.

Specifically this classification relates to situations where the aggressor was actually a member of the management or executive team and therefore respondents did not feel that it was prudent to report let alone obtain post-incident support. Alternatively, conflicts were seen to arise for management when a target of OVA accused a friend of their manager or supervisor. Finally, respondents saw management conflicts in terms of how to balance post-incident support against relationships with specialist doctors or potentially negative publicity.

Because there is no follow up of any issues in the workplace by the management who are usually the ones doing the bullying/displaying the intimidating/aggressive behaviour. ***– Enrolled nurse, aged care facility.***

Because the person who was the perpetrator is a high level executive in my organisation and I had no one whom I trust to report it to. ***– Registered nurse, community.***

Because the supervisor is the offender and the one to report to. ***– Registered nurse, private hospital.***

When it is the person in charge there is no one else to get support from! ***– Enrolled nurse, private hospital.***

ANUMs only look after certain staff that they like - other staff they are not interested in. ***– Registered nurse, private hospital.***

Some staff are more valued and supported than others by management. ***– Registered nurse, public hospital.***

Manager has favourites. Will not listen to criticism of her cronies/ buddies. Manager encourages division amongst staff. Quickly escalates reporting of those she does not like. ***– Midwife, private hospital.***

The hospital prefers not to have to deal with surgeons as they are a primary customer. Post incident support would validate the problem. ***– Registered nurse, private hospital.***

Management not interested and wanting to avoid any unnecessary publicity for the facility. ***– Registered nurse, aged care facility.***

No follow-up. Some respondents reported that despite reporting OVA or discussing incidents with managers they did not received post-incident support because managers did not follow up on the incident. This lack of follow-up was reported to occur at all levels of management for both formal and informal reports of OVA.

Our senior management don't think of doing this. It is a common occurrence and they don't acknowledge it even occurring even if an incident report is done there is no feedback. ***– Registered nurse, public hospital.***

Incident report was submitted and management asked if we are okay and that is it. I don't consider this to be support. No offer of staff care, sometimes staff involved in incidents don't even see anyone from management. ***– Registered nurse, aged care facility.***

Noted on RiskMan by management that they would counsel or offer counselling, but it never happens. They seem to think that just because they write it, it looks like they have done the right thing. That is all that matters, as long as they are seen to have done the job. ***– Enrolled nurse, public hospital.***

I was never given a reason despite asking verbally and in writing several times. ***– Enrolled nurse, private hospital.***

Management does not reply or speak to staff when an incident report is entered. I know of only one time that management has interviewed staff and that is when a resident punched a resident on the nose and the staff member required medical treatment. Other staff members have been hit, punched and bitten by one resident in particular, incident reports entered but no action taken by management. ***– Registered nurse, aged care facility.***

Management do not give staff feedback. ***– Enrolled nurse, aged care facility.***

I believe RiskMan is for the sake of keeping statistics rather than addressing the issues at work place and providing support to the workers who are affected by incidents. Workers are expected to perform to the highest standards. But, when they are attacked and abused by the patients or relatives the authority turn a blind eye towards them. Who is really worried about the staff? ***– Registered nurse, public hospital.***

No one at my workplace followed up on RiskMan that was submitted. ***– Enrolled nurse, public hospital.***

Part of the job. Respondents in some job roles and workplaces indicated that receiving post-incident support was unlikely because the experience of OVA was considered to be part of their job. Specific examples of such jobs include being a nurse unit manager (NUM) or working in emergency departments or aged care facilities where OVA is more prevalent. For these respondents, the prevalence of OVA incidents led to an acceptance of these interactions as 'normal' by staff and management.

We noted earlier that OVA is a high frequency event for many healthcare workers. Perhaps as a consequence of this, several respondents' comments reflected a view that OVA is widely accepted as a 'normal' part of the work experience for the nursing and healthcare workforce.

As NUM I am the one that deals with it. ***– Registered nurse, public hospital.***

Because I am a Senior Nurse, the expectation is that I will cope and that support is unnecessary. ***– Registered nurse, public hospital.***

I think it is accepted in the inpatient mental health unit where I work that patients will be verbally and physically aggressive towards nurses. ***– Registered nurse, public hospital.***

Deemed normal behaviour of the resident. Effect on staff irrelevant. ***– Enrolled nurse, aged care facility.***

It's accepted as part of the dementia medical condition that residents can become physically aggressive. Verbal abuse from family relatives occurs occasionally but management are not concerned. ***– Registered nurse, aged care facility.***

It is expected to be a part of the job that comes with working with aged care & dementia. ***– Enrolled nurse, aged care facility.***

In the emergency department aggression is often by psychiatric patients and is usually accepted as the norm. In the same way upset family members who vent their frustrations on us also goes with the territory. ***– Registered nurse, public hospital.***

It is such a common occurrence. It is accepted as a part of the life of an emergency nurse and there is a culture of acceptance. ***– Registered nurse, public hospital.***

Aggression is viewed as "normal" by some co-workers and more so management. ***– Enrolled nurse, aged care facility.***

Is considered normal part of our job for some aggression from patients. ***– Registered nurse, community****.*

It is such a common occurrence. It is accepted as a part of the life of an emergency nurse and there is a culture of acceptance. ***– Registered nurse, public hospital.***

There are regular incidents of 'aggression' and 'bullying' by some medical staff (surgeons and anaesthetists). It is considered 'part of the job.' ***– Registered nurse, public hospital.***

Because aggression from doctors is considered "normal" or "standard". Nurses are expected to "deal with it", or "work in a different area." ***– Registered nurse, private hospital.***

While the experience of OVA is viewed by many healthcare workers as 'part of the job', for some respondents, patient pathology is viewed as an overriding reason to overlook violent or aggressive incidents. There is a perception that the patients cannot help their actions.

Patient aggression often occurs in ICU as patients are elderly, affected by medication and often get very confused and therefore aggressive. It seems to go with the territory. ***– Registered nurse, private hospital.***

Because I work with aggressive patients and don't bother doing a riskman on every violent occasion. ***– Enrolled nurse, public hospital.***

Because in aged care you always deal with clients who may be violent , angry or be suffering from a disease process that affects their mental capacity to make good decisions all the time. ***– Registered nurse, public hospital.***

Aggression from residents is a side effect of their condition and is considered to be a part of our job in aged care. ***– Enrolled nurse, aged care facility.***

Violence from patients is an ongoing issue in the critical care area mainly due to the effects of drugs and pain. ***– Registered nurse, public hospital.***

4.3.4. Individual level

Comments associated with the individual (*n* = 567) are those that tended to be more specific to the individual's view about whether or not OVA needed to be reported and whether or not post-incident support was required. However, it should be noted that while these views arise from the individual, they are still informed to some degree by respondent perceptions of the broader workgroup and organisational culture.

Figure 15 below displays the percentage of comments in each sub-theme at the individual level. Generally, these respondents indicated that they did not receive post incident support because they did not report or request it or they felt it was not required. Additionally, some respondents saw their lack of status within the organisation (e.g., personal carer, bank staff) as a barrier to receiving post-incident support.

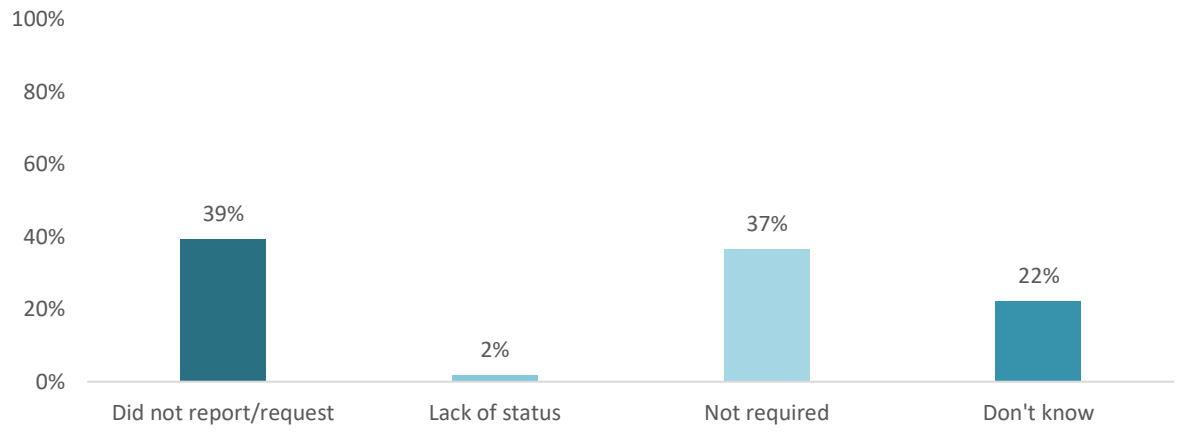

Figure 15: Perceptions of lack of support due to individual factors

Did not report or request. Many respondents stated they did not receive post-incident support because they had not reported the incident in the first place. Where respondents offered reasons for not reporting OVA, those reasons tended to be that they would debrief among themselves, acceptance that OVA is part of the job, the aggression was minimal or they did not expect that there would be any follow-up to the incident.

> *Didn't report it, we generally debrief amongst ourselves.* ***– Registered nurse, public hospital.***
>
> *The incident was not reported. This happens on an almost daily basis, and rarely gets reported.* ***– Registered nurse, private hospital.***
>
> *Not reported. Part of the job in a busy birthing unit.* ***– Midwife, public hospital.***
>
> *I did not report incidences as I accept them as part of my work as a nurse.* ***– Registered nurse, public hospital.***
>
> *Was not formally reported due to mildness of the aggression.* ***– Enrolled nurse, aged care facility.***
>
> *Reports are never made on workplace incidents of this sort.* ***– Registered nurse, private hospital.***
>
> *Incident was not reported on RiskMan because nothing ever happens!!* ***– Registered nurse, public hospital.***

Similarly, many respondents indicated that they had [or may have] reported an incident yet did not request post-incident support. Again, respondents did not always offer a reason for not requesting post-incident support but some of those that did indicated that they felt it was unnecessary. Not requesting post-incident support was also associated with situations where colleagues helped to debrief, there was minimal harm done, or they felt that they were able to cope with or resolve the situation by themselves.

> *Didn't request it and it is common place in ED. Colleagues are very supportive.* ***– Registered nurse, public hospital.***
>
> *Did not request support, generally informal support provided by co-workers.* ***– Registered nurse, public hospital.***

Not sought. Over the years I have developed a thick skin. ***– Registered nurse, private hospital.***

I did not feel the need to request support post patient incidents. ***– Registered nurse, private hospital.***

I did not request it, and it was not offered. ***– Registered nurse, public hospital.***

Did not seek it, as nothing would be done. ***– Registered nurse, aged care facility.***

Didn't feel it serious enough to warrant support / debriefing. ***– Registered nurse, public hospital.***

Because I didn't make a big fuss about it. ***– Registered nurse, aged care facility.***

Additionally, some respondents did not report OVA or seek post-incident support because they felt there would be negative consequences for them if they did. In particular, they stated that they would be seen as not able to cope or that fear of reprisals from senior staff meant that they could not access support. Furthermore, some staff felt that their employment would be threatened if they reported OVA or requested post-incident support.

It is considered part of the job and if I requested post incident support I would be talked about in the unit as soft or unable to cope. ***– Enrolled nurse, public hospital.***

Did not want to complain or appear weak. ***– Registered nurse, community.***

I did not report it as previous experience of reporting to HR resulted in further discrimination both from HR and supervisor. ***– Registered nurse, public hospital.***

There is no point saying anything as it ends up in HR and becomes worse. ***– Registered nurse, public hospital.***

There is a bullying culture at my workplace. It is best not to say anything. ***– Registered nurse, public hospital.***

There is no way to access support without making bullying/workplace aggression worse. The organisational culture protects perpetrators and offers little material support to those who experience violence. ***– Midwife, public hospital.***

I did not report it to my supervisor. An episode of extreme verbal abuse from a colleague was not witnessed by anyone else and I feel that therefore it would seem as though I was "telling tales". I have ignored this behavior as it occurred once. I hope if it occurs again, that I would be more proactive. ***– Registered nurse, aged care facility.***

The staff member involved is a long standing staff member who carries a lot of power and is able to influence senior staff to her advantage and to disadvantage other staff members. Therefore co-workers do not feel supported enough to approach senior staff. ***– Registered nurse, public hospital.***

Because it happens on a regular basis and there is nothing that can be done about it without consequences. ***– Midwife, public hospital.***

Because patients, relatives and friends are never wrong! And there is always repercussions if management is challenged. ***– Enrolled nurse, aged care facility.***

Lack of status. Some respondents felt that they were unable to speak to more senior members of staff about their experiences of OVA due to their lack of status.

> *As an enrolled nurse I am treated like an invisible or untouchable who is not as important as RNs. –* ***Enrolled nurse, public hospital.***
>
> *Because there is a culture of bullying on my ward that the entire hospital is aware of. I believe it has tacit approval from the NUM and some ANUMs. The graduate nurse program refuse to acknowledge what the grads are experiencing and I was discouraged from approaching the union. –* ***Registered nurse, public hospital.***
>
> *Agency staff. No follow up, explanation or apology from staff member. Followed up with my employer at agency.* ***– Enrolled nurse, aged care facility.***
>
> *No follow up by managers to the persons involved, if you're not a grad or overseas midwife you're not supported.* ***– Midwife, private hospital.***
>
> *Intimidation and bullying is rampant from" some" senior RNs and in-charge staff, who generally look down on personal care workers as inferior. Personal carers in this workplace are afraid to report standover tactics as there appears to be "no confidentiality" in our workplace and the behaviour increases once reported. The problem actually extends to senior management, and there appears to be nowhere else to go. Most personal care workers are afraid to report.* ***– Personal carer, aged care facility.***
>
> *They would rather sweep it under the rug. After all you're only a PCA. A nothing, so the client is more important, whatever it was, must be your fault.* ***– Personal carer, aged care facility.***
>
> *Considered to be just normal behaviour from visitors, patients and families. Also supervisor and unit manager have all the power over Bank staff. We just don't get offered work. End of their problem.* ***– Registered nurse, private hospital.***

4.4. Why do some healthcare workers not seek post-incident support?

As noted in the analysis at the individual level, there was a subset of respondents who did not report incidents or request post-incident support (*n* = 223). We sought to expand our understanding of these comments and examine why these respondents did not report or request post-incident support through formal channels or felt that post incident support was not required by conducting a post-hoc analysis.

It was beyond the scope of the broader survey to delve into why respondents did not request or need post-incident support so there was no direct question about this. While nearly half of these respondents did not give a reason for not reporting or requesting post-incident support, 133 respondents did give more detailed answers. This section is a summary of those additional comments that, where provided, shed light on why some respondents thought it unnecessary to request post-incident support.

The reasons for why this subset of respondents did not request post-incident support include: able to cope, too busy, conflict with managers, the incident was minor or they were not injured, part of the job and because the incident was resolved at the time. The distribution of these comments can be seen in Figure 16 below.

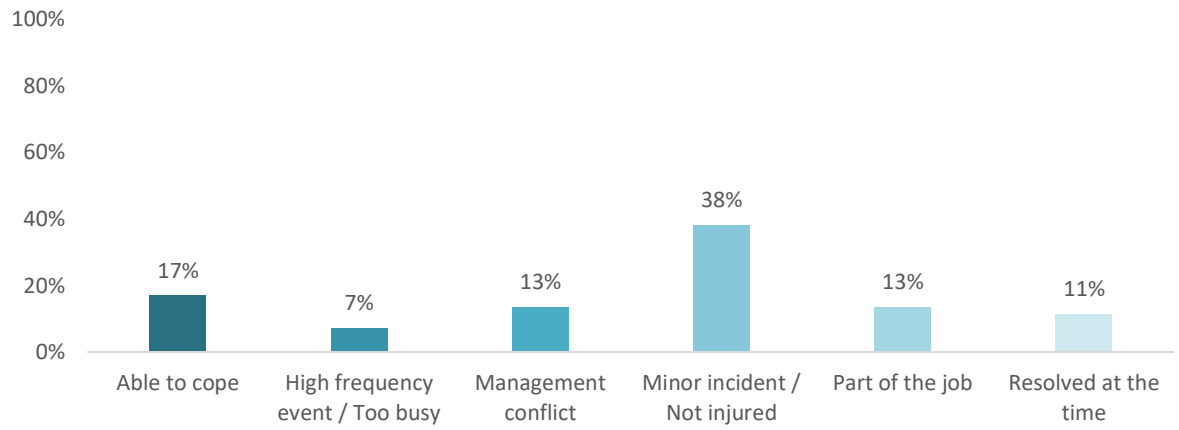

Figure 16: Reasons for not requesting post-incident support

Able to cope. Some respondents reported that they were able to cope without additional support. In general, comments in this category indicated that the respondent was less stressed by verbal aggression. Some reported that they had the confidence or experience to handle incidents without additional support.

> *Aggression was verbal and did not stress me unduly.* ***– Personal carer, community.***
>
> *I handled the situation and resolved it to my satisfaction.* ***– Registered nurse, aged care facility.***
>
> *Was able to put it into perspective and recovered well from it.* ***– Midwife, public hospital.***
>
> *I probably didn't actively seek support at the time as I felt I could handle the situation in a professional manner without requiring extra support.* ***– Registered nurse, public hospital.***

High frequency event/Too busy. In this category respondents reported that they did not request post-incident support due to a lack of time or because aggression is a regular event that makes reporting too difficult to incorporate into other daily activities.

> *Didn't report it. I'd be too busy reporting, instead of working. It's best just to suck it up. Have as minimal interaction with the bullies, nasties, etc.* ***– Registered nurse, public hospital.***
>
> *Not reported to anyone, verbal abuse from patients in a public hospital is a regular occurrence and not worth reporting, would waste too much time on the tiresome task of reporting this on riskman. Little can be done about verbally abusive patients, so you unfortunately have to have a thick skin, ignore it and put up with it.* ***– Enrolled nurse, public hospital.***
>
> *Occurred during handover at the end of work shift, just before I was leaving. It was observed by my team leader who was quite busy and I did not request support and left.* ***– Midwife, public hospital.***

Management conflict. In this category respondents reported that the reason they did not request post-incident support was due to a conflict with management. In these cases it was because managers were seen as the aggressor and there might be negative consequences if post-incident support was requested.

> *I did not request any as the stress was from my line manager.* ***– Registered nurse, aged care facility.***
>
> *Incidents not submitted as by senior staff members/s. I have found it better to ignore such instances & keep a diary & take a sick day. I fear & have endured nasty meetings designed to intimidate, holidays not being approved & unfair rostering & extra night duty & on call as "pay back".* ***– Midwife, private hospital.***
>
> *There is no way to access support without making bullying/workplace aggression worse. The organisational culture protects perpetrators and offers little material support to those who experience violence.* ***– Midwife, public hospital.***

Minor incident/not injured. If an incident was considered minor or there were no physical injuries, respondents reported they did not feel the need for post-incident support. Some respondents reported that verbal or passive aggression were not the types of incident that required post-incident support. Additionally, if an incident was mild and coupled with patient pathology, post-incident support was not considered necessary.

> *The level of violence/aggression was such that I was unharmed and unconcerned.* ***– Registered nurse, public hospital.***
>
> *The incident was not bad enough to warrant support..* ***– Enrolled nurse, community.***
>
> *Incident was not serious and did not affect me afterwards.* ***– Registered nurse, public hospital.***
>
> *Was not formally reported due to mildness of the aggression.* ***– Enrolled nurse, aged care facility.***
>
> *Not required as often passive or verbal aggression.* ***– Registered nurse, public hospital.***

I didn't feel the need as it was not something that really worried me to a great extent as it was just verbal aggression. I can let these incidences roll off me if it's not too aggressive. ***– Midwife, public hospital.***

Didn't think it was needed. No one physically hurt. ***– Registered nurse, public hospital.***

These were mild incidents caused by an anaesthetised patient or one under the influence of anaesthetic drugs where the patient was not accountable for their actions. ***– Registered nurse, public hospital.***

Part of the job. In this category respondents reported that the reason they did not request post-incident support because OVA is viewed as part of the job or because the incident was associated with patient pathology.

I did not seek it, was usually someone demented or had other behavioural problems. Par for the course. ***– Enrolled nurse, public hospital.***

I never requested it. It's just considered part of my job. ***– Registered nurse, public hospital.***

Considered the patient had dementia and no further action was required. ***– Enrolled nurse, aged care facility.***

Because the patient is 'always' scratching, biting, etc, and is confused. ***– Registered nurse, private hospital.***

I did not feel that I required any, as the patient was acutely psychotic. ***– Registered nurse, public hospital.***

Resolved at the time. Some respondents reported that they did not require additional support because issues are resolved at the time. Employing strategies to deal with aggression at the time was also seen as a reason to not request post-incident support.

Staff have strategies to deal with these behaviours, mainly walking away and often you don't require debriefing or support. ***– Enrolled nurse, aged care facility.***

Aggression came from dementia residents, as handled appropriately, no support needed. ***– Enrolled nurse, aged care facility.***

The situations were de-escalated as they occurred and personally I felt no need for added support. ***– Midwife, public hospital.***

It was not needed code was called and once it was stood down we all went back to duties. ***– Registered nurse, public hospital.***

Was not formally reported. Also dealt with at the time with the people involved. ***– Enrolled nurse, public hospital.***

While this analysis focuses only on the respondents who reported that they did not receive post-incident support, some of the respondents did not request post-incident support because they were able to access support through informal channels. These comments on informal sources of support provide an additional perspective for how workers could be supported following the experience of OVA. Sixty-one (4%) respondents reported that they accessed post-incident support through informal channels and Figure 17 below shows the distribution of the sources or types of informal support.

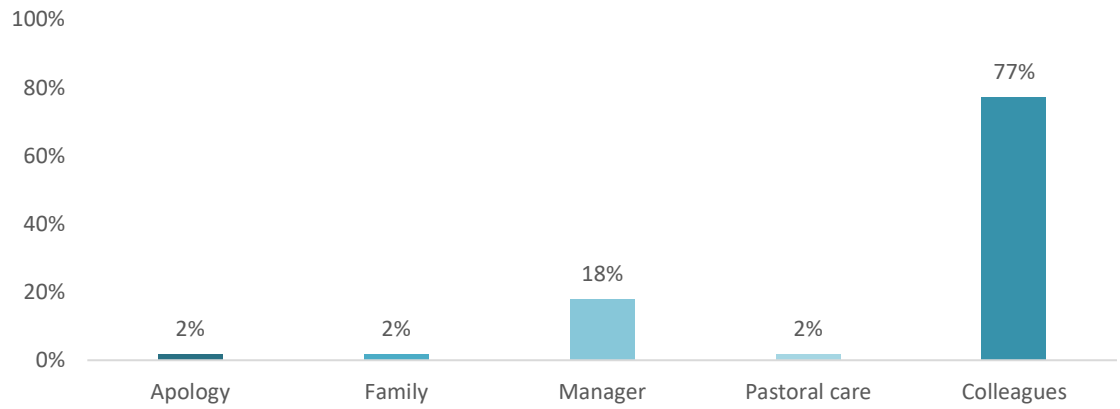

Figure 17: Sources/types of informal post-incident support accessed by respondents

Informal support from colleagues. Most respondents reporting some kind of informal post-incident support said that this support came from colleagues. This type of support was sought because support from management may not be provided. Even if formal channels of support were available, some respondents saw value in informal support because they were employed in busy workplaces that made accessing formal channels of post-incident support difficult.

> *It's very common so we are used to it, too busy to worry about follow up, the staff just support each other informally.* ***– Enrolled nurse, public hospital.***
>
> *Peer support very good, often deal with substance affected patients and psyche patients who are abusive and difficult, we all support each other, usually plenty of staff in vicinity.* ***– Registered nurse, public hospital.***
>
> *Not necessary, informal support from colleagues as needed.* ***– Registered nurse, general practice.***
>
> *It's not the culture. Nurse usually debrief informally through end of coffee and chat.* ***– Registered nurse, public hospital.***
>
> *Only supported by my fellow nursing staff rostered that shift, not from my manager.* ***– Registered nurse, public hospital.***
>
> *A great deal of peer to peer debriefing occurs but generally in house debriefing/counselling is only provided if instigated by ANUMS, OHS representative or union representative.* ***– Registered nurse, public hospital.***
>
> *Shift was busy, even on return to work no questions as to how I was physically or emotionally. It is like who cares? Some work colleagues are very supportive and likewise I support them as well. But management leave a lot to be desired with regards to support.* ***– Enrolled nurse, aged care facility.***
>
> *Happens on a daily basis in ED! We have a great team and we debrief with each other. We only have to ask and a formal debrief would be organised.* ***– Registered nurse, public hospital.***
>
> *We have informal debriefs and generally organise our own supervision. Unless it is a particularly nasty incident, then management organises debriefing.* ***– Registered nurse, public hospital.***

Other informal support. Some respondents reported their post-incident support comprised informal talks with managers or supervisors. Others indicated that family or other means of support were sourced.

> *Only one incident was reported, and apparently a 'chat' I had with the DON was my debrief - fair to say though I didn't ask for further support. Incident involved an aggressive relative..* ***– Registered nurse, public hospital.***
>
> *The floor manager & ED doctor did give me debriefing post incident that night. However, the NUM only asked would I feel alright after I returned to work with few days off.* ***– Registered nurse, public hospital.***
>
> *Was not necessary. A quick debrief with nurse in charge was all I needed.* ***– Registered nurse, public hospital.***
>
> *It was verbal abuse that I handled myself. My supervisor asked if I was ok and when I said I was, no further support was given.* ***– Registered nurse, aged care facility.***
>
> *Informal debrief with supervisor only. I was happy with outcome.* ***– Midwife, public hospital.***
>
> *Not required as I was able to debrief with colleagues and family.* ***– Registered nurse, public hospital.***
>
> *An apology was granted to me.* ***– Registered nurse, private hospital.***
>
> *As the NUM, I organised the support for other staff. When the aggression was directed solely at me, I accessed my own support, it was not offered by my line manager.* ***– Registered nurse, public hospital.***

5. Conclusion and Recommendations

This report is part of our larger research project that documented workplace health and safety in the nursing and caring profession.[1] Our earlier research has shown that OVA is prevalent in Victorian healthcare[1, 35] and this report complements that work by examining the key barriers or challenges to receiving post-incident support following the experience of OVA. Specifically, this report represents the perceptions of healthcare workers who have experienced OVA but have not received post-incident support. We examined these views at societal, organisational, workgroup and individual level.

The first research question was: Who is more likely to receive post-incident support? The results showed few differences among demographic groups with regard to provision of post-incident support. Registered nurses and enrolled nurses were more likely to receive post-incident support compared to midwives and personal carers. Respondents employed in public hospitals, private hospitals and aged care facilities were less likely to receive post-incident support compared to those working in general practice, local government and community settings. However, no statistically significant differences were observed on the basis of age, workplace tenure or employment status.

Research question 2 asked: What are the societal, organisational, workgroup, and individual reasons that healthcare workers do not receive post-incident support? We categorised answers to this question into four levels of analysis: society, organisation, workgroup and individual. Respondents' perceptions on why they did not receive post-incident support were primarily focused at the workgroup or individual level, followed by the organisational level with very few comments at the societal level.

At the societal level of analysis comments primarily connected the experience of OVA in healthcare with trends that have resulted in OVA becoming a socially accepted part of the job for nurses and midwives. Specifically, workers reported that OVA was influenced by problems within society that included a lack of civility, a sense of entitlement, patients being under the influence of drugs and the level of violence in computer games normalising violence in general. Comments also reflected concerns that healthcare workers were not respected in society as professionals and that OVA in healthcare was becoming normalised.

At the organisational level of analysis, comments were grouped into four sub-themes: lack of prioritisation of occupational health and safety, lack of resources, post-incident support was not available or not offered, and OVA was seen as a high frequency event. These comments were dominated by the sense that staff concerns were not taken seriously by management, due to a lack of leadership commitment to OHS, and that the needs of patients and their relatives were given priority over staff health and safety. There was also the perception that there were not enough resources available to report OVA or access support. Difficulties highlighted in these comments showed that the RiskMan reporting system was too cumbersome, and staff who work out of standard office hours do not have ready access to post-incident support due to lack of available staff. Respondents also saw themselves as too busy and unable to take time away from their patients to report OVA or access support. This was compounded by OVA being reported as a high-frequency event with incidents occurring so often it was not possible to take time to report each incident. Finally, some respondents reported that post-incident support was not offered at their organisations as there were no policies in place and no official channels of support.

Comments categorised to the workgroup category were categorised into five sub-themes: managers or supervisors do not care or are not supportive, a culture of fear and blame, management conflicts, no follow up, and managers or supervisors saw OVA as part of the job. Some respondents reported that they believed that management did not take OVA seriously, did not care or did not respond to staff concerns effectively. There were respondents who felt that there was a culture of fear and blame in their workgroup so they did not wish to report OVA. These respondents indicated that if they reported an incident they would either be blamed for the incident or they would be seen as weak or unable to cope with their job. Some respondents believed that managers and supervisors were sometimes compromised in their reactions to staff reports of OVA due to conflicts of interest. Workers reported that seeking post-incident support was not possible when the aggressor was a direct supervisor or manager, a member of senior management, a specialist doctor or a friend of the manager. The lack of management follow-up on reports of OVA was also seen as discouraging by those who reported incidents. Respondent comments indicated a lack of follow-up on both formal reports such as RiskMan and informal discussions with management. Finally, in some workgroups such as emergency departments or aged care facilities, respondents referred to a culture of acceptance that OVA was part of the job and healthcare workers were too busy to report or seek support following the experience of OVA.

At the individual level, several issues were identified as influencing the likelihood that healthcare workers would receive support. Although, it is important to note that while these issues arise at the individual level, they are still informed to some degree by their perceptions of the broader workgroup and organisational culture. These issues were classified into four categories: did not report OVA and/or did not request support; felt support was not required; lack of status; and don't know. Not reporting OVA or not requesting support and feeling that post-incident support was not required were the dominant themes at this level of analysis. This situation was further exacerbated for those who saw themselves as lacking in status such as enrolled nurses and agency staff.

Research question 3 asked: Why do some healthcare workers not seek post-incident support? Analysis of comments that were classified as 'did not report,' 'did not request post-incident support' and 'not required' shows that there were numerous reasons for why respondents did not report or request post-incident support. These reasons include: being able to cope with the incident; they were too busy; conflict with managers; they incident was minor or they were not injured; OVA as part of the job; and because the incident was resolved at the time. The dominant reason was because the incident was minor or they were not injured. However, some respondents saw themselves as being able to cope particularly if the aggression was verbal rather than physical.

Analysis of a small subset of comments that addressed informal sources of post-incident support showed that some respondents reported that they accessed post-incident support informally from colleagues, managers and family. Most informal support was provided by colleagues, particularly for those who were employed in busy workgroups such as emergency departments. It should be noted that this was not a comprehensive analysis of informal support as that is beyond the scope of this study. However, these comments are informative and offer a fruitful avenue for future research. They also demonstrate an element of post-incident support that has the capacity to work well for some respondents.

This report represents the perceptions of healthcare workers who have experienced OVA but have not received post-incident support. The comments represent a rich form of data that is

not always possible to elicit from a quantitative analysis. It is important to note that while these comments, which are often emotive and challenging in their content, are a reflection of the actions (or inaction) of individual managers, supervisors and other staff, they may not be reflective of or aligned with general organisational policies. Nonetheless, they still represent valid opinions and experiences of those affected by OVA and as such they have been valuable in highlighting systemic weaknesses in some healthcare workplaces that are in need of improvement.

5.1. Future directions

While it is clear that substantial responses to OVA in the healthcare sector are being made by government[22, 23] and unions[24], research evidence and understanding of post-incident reporting and support at the organisational level is sparse. The provision of post-incident support is a complex issue and the requirements for post-incident support could be expected to vary according to the unique circumstances of each workplace and the needs of the individual. Future research could investigate in greater detail the current levels and features of post-incident reporting and support. An important next step for research would be to evaluate post-incident support; it is crucial to build understanding of what works in post-incident support for healthcare workers. This research would contribute to a better understanding of the prevention, management and reduction of OVA.

A positive feature identified in the thematic analysis was that while management support is needed and must be provided in order to resolve incidents and reduce the negative consequences of experiencing OVA, support from colleagues was reported to be a valuable source of post-incident support by some respondents particularly in high pressure working environments such as emergency departments. Investigating how this process could be formalised into a peer post-incident support network would also be a useful avenue for future research.

5.2. Recommendations

Recent reports by the Victorian Auditor General's Office[23, 30] and the 2016 Violence in Healthcare Taskforce report[25] indicate collaborative and ongoing efforts to address OVA. We note that the Taskforce has identified a set of recommendations to deal with OVA in healthcare, which included the recommendation to "develop and implement a simplified reporting system". We endorse the recommendations of the Taskforce. We also note that the *2013 Occupational violence incident response guide for employers*[31] offers a comprehensive framework of advice and guidance.

The comments analysed for this report show that certain areas within the healthcare system, such as emergency departments, mental health facilities and aged care facilities, present distinctive challenges for the reporting of OVA and therefore requesting post-incident support. In any context, there are numerous issues to be resolved to ensure the risk of OVA is reduced and staff have the capacity to access support where needed.

Our recommendations are intended to offer guidance for practical actions that could be introduced at organisational and workgroup levels. Overall, this research has contributed to a better understanding of OVA in healthcare and factors related to reporting and post-incident

support. There would be further value in research that evaluates real-world implementation of interventions aligned with our recommendations.

We recommend addressing workplace and organisational culture to reduce and prevent:

1) incivility within the work environment;
2) a propensity to blame the victim; and
3) the view of OVA as being 'just part of the job' for healthcare workers.

This could be facilitated by promoting: respect for employees; reinforcing zero tolerance for violence (e.g., ANMF (Victorian Branch) 10 point plan to end violence and aggression); and formal and informal support mechanisms that allow employees to debrief following incidents of OVA.

With respect to organisational practices we recommend:

4) designing and implementing a process of accountability for leaders, managers and supervisors with respect to OVA prevention, management and response;
5) training in debriefing for supervisors and co-workers who find themselves assisting an employee who has experienced OVA incidents;
6) prioritising occupational health and safety at the same level of patient safety;
7) ensuring there is a simplified but formal process through which OVA can be reported and workers can seek support as required; and
8) creating opportunities for staff to report OVA and request support within work time.

5.3. Conclusion

Overall, this research has contributed to a better understanding of the barriers or challenges Victorian healthcare workers face with respect to post-incident support following the experience of OVA. By investigating the barriers and challenges related to the reporting of OVA, this report builds on the previous efforts and identifies areas for the development and implementation of policy, workplace-based strategies, evaluation and research focused on OVA.

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