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The way we do things around here. A qualitative study of the workplace aggression experiences of Victorian nurses, midwives and care personnel

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ABSTRACT

Background: Workplace aggression in the health and care sectors is a major work health and safety and public health concern, worldwide. In Australia, rates of exposure to workplace aggression are consistent with those experienced by nurses internationally, and have not decreased over the past 35 years.
Objectives: To explore the experiences and perspectives of nurses, midwives and care personnel relating to experiences of verbal or written and physical aggression from external sources (patients, patients' relatives or carers and others external to the workplace) and internal sources (co-workers).
Design: A pragmatic, descriptive, qualitative study, integrating themes emerging from online survey comments and follow-up, in depth interviews.
Settings: Health and aged care services in the Australian State of Victoria.
Participants: Nurses, midwives and care personnel who were members of the Australian Nursing and Midwifery Federation – Victorian Branch in May and June 2017.
Method: Thematic analysis was undertaken on the combined comments provided in up to seven free-form text fields of an online survey questionnaire and the content of follow-up interviews of selected survey participants.
Results: From the online survey data, comments from 623 participants were able to be included in analyses. Of the 293 respondents initially indicating a willingness to be contacted by researchers, a sample of 29 participated in in-depth interviews. Eight thematic categories emerged from the data, relating to patient aggression, contextual categories (three sub-categories – care of older people, mental health care and emergency department settings), co-worker aggression (two sub-categories – aggression from managers/supervisors, aggression from colleagues/peers), reporting behaviours, trade union involvement, security personnel and police involvement, legal action and the impacts of workplace aggression.
Conclusions: Over the past 35 years, little progress has been made in mitigating the likelihood and consequences of this serious work health and safety, and public health issue. There appears to be have been a sustained failure to implement co-ordinated, multi-sectorial, system-wide and targeted interventions to reduce what seem to be growing levels of harmful exposure to incivility and aggression in care settings in Victoria. There is an urgent need to strengthen and enforce existing legislation, introduce new laws and develop more effective systems and practices to adequately protect the health and safety of nurses, midwives and other care personnel in their daily work. Stronger evidence for system and service level interventions to prevent and minimise workplace aggression in care settings is also required.

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Summary of relevance

Problem or Issue

Workplace aggression is an endemic work health and safety concern in health and aged care work, but little is known about direct individual experiences, including reporting motivations and behaviour, or experiences and outcomes of seeking support following exposure to workplace aggression.

What is Already Known

There is an established body of evidence on the high rates and concerning impacts of workplace aggression in nursing and healthcare more broadly, across the world. In Australia, rates of exposure to workplace aggression have continued to increase over the past 35 years.

What this Paper Adds

This study is one of the few to document nurses' and midwives' direct experiences of workplace aggression, their descriptions of reporting aggression in the workplace, and their experiences of seeking advice and support from their employers, professional organisations, work health and safety authorities, police and other legal services. This paper brings to light the urgent need to strengthen and enforce existing legislation, introduce new laws and develop more effective systems and practices to adequately protect the health and safety of Victorian nurses, midwives and other care personnel in their daily work.

1. Introduction

An established body of peer-reviewed literature highlights the high rates and concerning impacts of workplace aggression in nursing across the world (Alameddine, Mourad, & Dimassi, 2015; Clausen, Hogh, & Borg, 2012; Edwards & Buckley, 2016; Farrell & Shafiei, 2012; Fujita et al., 2012; Gascón et al., 2009; Spector, Zhou, & Che, 2014). Sustained exposure to aggressive acts can lead to disengagement from the workplace, and the physical and emotional impacts can result in alienation, turnover or decisions to leave the profession altogether (Edward, Ousey, Warelow, & Lui, 2014; Edward et al., 2016; Estryn-Behar et al., 2008). In Australia, rates of exposure to workplace aggression are consistent with those experienced by nurses internationally, and have not decreased over the past 35 years (Hegney, Tuckett, Parker, & Eley, 2010; Hills, Lam, & Hills, 2018; Holden, 1985; O'Connell, Young, Brooks, Hutchings, & Lofthouse, 2000). Few studies, however, have documented nurses' and midwives' own voices, their direct experiences of workplace aggression, their descriptions of reporting aggression in the workplace, or their experiences of seeking advice and support from their employers, professional organisations, work health and safety authorities, police or other legal services (Edward et al., 2014).

It is important to consider more constructivist approaches to understanding complex problems such as workplace aggression, which has mostly been dominated by cross-sectional prevalence studies. A constructivist approach is primarily concerned with understanding the human experience (Polit & Beck, 2018). This study was undertaken as a part of the larger Workplace Aggression Experiences of Victorian Nurses and Midwives survey, which has highlighted the high levels of exposure and varied responses to workplace aggression in health and aged care settings (Hills et al., 2018). The aim of the current study was to explore the experiences and perspectives of nurses, midwives and care personnel in the Australian State of Victoria relating to exposure to verbal or written and physical aggression from external sources (patients, patients' relatives or carers and others external to the workplace) and internal sources (co-workers). In particular, the researchers sought to obtain deep insights into their reporting behaviours and support sought from employers, health services, Trade Unions, work health and safety agencies, police and legal services in relation to their experiences of workplace aggression.

2. Methods

This pragmatic, descriptive, qualitative study was undertaken in four stages. Firstly, an online survey of the membership of the Australian Nursing and Midwifery Federation – Victorian Branch (ANMF-VIC) was conducted between 1st May and 30th June 2017, through hyperlinks in three emailed ANMF-VIC notices (Hills et al., 2018). The online questionnaire gathered personal profile data and reported frequencies of exposure to workplace aggression from internal and external sources in the previous 12 months. It also gathered reported responses to this aggression (including reporting behaviours and support sought from the employer, health services, Trade Unions, work health and safety agencies, police and legal services), the presence of aggression prevention and minimisation actions and responses, personal health and well-being information, and workforce participation intentions (Hills et al., 2018). Space was provided for comments at the end of each section in the questionnaire in free-form fields, with the intention of extracting respondent comments for later analysis. A final item asked whether respondents were willing to undertake a personal, in-depth interview with a member of the research team. Analyses of the questionnaire free-text comments and in-depth interviews are the focus of the current study.

In the second stage of the study, semi-structured interviews were conducted with respondents who indicated that they were willing to talk with a researcher. Three members of the research team contacted a sample of 52 potential interview participants from a total of 293 respondents who had initially indicated a willingness to be interviewed. The sample was chosen by scanning a table of the respondents and selecting potential interviewees on the basis of a spread of age, sex, profession, service type, and metropolitan, regional and rural location. Individuals were approached via email and telephone, with 30 formally responding and assenting to participate in in-depth interviews. Interviews were conducted by the researchers between 1st August and 30th November 2017, in person and via telephone. Participants were asked a schedule of questions regarding their experiences of workplace aggression and their responses to this aggression, but with freedom to discuss related issues and concerns. All interviews were recorded and the audio files were independently transcribed. When the researchers agreed that data saturation had been achieved, the interviews were ceased. Thematic analysis was undertaken in January 2018 by all four researchers, individually and then together.

In the third stage of the study, comments from the online survey were extracted in March 2018 for review and analysis by two of the researchers. Comments were tabulated, read and then re-read before classifying the substantial content into themes. Two substages of categorisation were undertaken, the first to categorise the main themes emerging from the analysis and the second to compare and matched the identified themes to those arising from the in-depth interviews in Stage 2. The final stage involved the integration of themes from Stage 2 and Stage 3. The results obtained were then reviewed again by all four members of the research team.

The conduct of the study was approved by the Monash University Human Research Ethics Committee (MUHREC) and conformed to the National Statement on Ethical Conduct in Human Research 2007 (National Health & Medical Research Council, 2015). The research team are experienced quantitative and qualitative researchers, with the lead investigator having extensive experience in workplace aggression research. In the first section of the online questionnaire participants were asked to read the explanatory statement, which outlined benefits and risks of participation and

Table 1
Thematic categories

Categories/sub-categories
1. Patient aggression
2. Context of patient aggression
a. Care of older people
b. Mental health care
c. Emergency department settings
3. Co-worker aggression
a. Aggression from managers/supervisors
b. Aggression from colleagues/peers
4. Reporting behaviours
5. Trade Union involvement
6. Security personnel and police involvement
7. Legal action
8. Impacts of workplace aggression

the information they would be asked to provide. The statement also indicated that participation was voluntary and that participants could withdraw from participation at any stage, including when completing the questionnaire. The statement provided details for contacting the researchers and the MUHREC regarding any issues of concern. Participants were required to indicate their consent to participate before they could proceed to the items in the questionnaire. At the end of the questionnaire, respondents were asked if they would be willing to speak with a member of the research team about their experiences of workplace aggression. This was the only section of the questionnaire where respondents' names and contact details were requested, and these details were removed from the main body of questionnaire responses for storage in a separate database so that privacy and anonymity could be preserved. Before participating in an interview, each participant was asked to confirm that they had read the explanatory statement and to consent to audio recording of the interview for later transcription. Any identifying information in transcribed interviews was removed before analysis and reporting.

3. Results

In Stage 2, 29 respondents were interviewed individually, either face-to-face or via telephone, and provided a representation across sex, age, discipline and metropolitan, regional and rural settings. From the online survey (Stage 3), 1222 respondents commenced the questionnaire (Hills et al., 2018) and 676 (55.3%) provided at least one comment. Of those, 235 (34.8%) provided comments in four to seven of the free-form comments fields. Comments from 53 (7.8%) comprised minimal content or were not comprehensible and were excluded from analyses. Finally, in Stage 4, thematic analysis resulted in eight thematic categories emerging from the data, two of which had sub-categories (Table 1). In the reporting of comments and quotations, the prefix 'C' refers to participants who were interviewed by members of the research team, while the prefix 'R' refers to comments by online questionnaire respondents.

Overall, participants felt betrayed by their profession/s and by the organisations for whom they worked. They came to work expecting to be assaulted in some way, either verbally or physically, by patients or their relatives, and they expected to have to deal with varying levels of civility and co-operation from their colleagues. Many had no faith in their organisation protecting or supporting them in the face of abusive behaviour or in the event of an assault. Indeed, they often did not report these incidents for fear of being blamed or for causing trouble, or for the mere fact of incident reporting systems being too cumbersome and resulting in no positive or visible outcome. Participants reported feeling powerless, disillusioned and angry. They wanted to be heard, yet feared the consequences. They were actively considering how they might have more control over where and with whom they worked, including by changing shifts, moving to casual work, changing career paths or resigning completely.

3.1. Patient aggression

Eighty nurses provided written comments about their experience of aggression from patients and experiences were also outlined by a number of interview participants. A common response from the participants was that verbal abuse and physical assaults by patients was an everyday experience and that there was not much that could be done about it. There were some harrowing accounts of physical assaults and harm, leading to hospitalisation and extended time off work. For example, R329 stated, *I was physically assaulted by a patient on the ward, I suffered lower back pain, neck pain and an intracranial bleed*. For R408, *I was off duty for 6 weeks due to patient aggression*. R425 explained, *I was assaulted by a patient, the terror I felt was significant and the fallout psychologically has been one of the hardest things I've had to deal with in my life*.

For C5, an experience of physical assault by a patient, which reportedly left her with ongoing anxiety and depression, was so traumatic that she requested it not be described in this report. C17 described being kicked and punched by a patient even when she had fallen to the floor and, although other staff members called the police and an ambulance, only the ambulance attended the scene of the offence. C24 reported being punched in the head while showering a patient. C4 described being tackled by a 140 kg man who had been assaulting another nurse and then being abandoned by other staff initially trying to subdue the patient, for what felt like a very long time until security arrived. A nurse working in education described a tense situation when a student was unhappy with his grades and threatened to . . . *come back and get somebody* (C13). Many more concerning examples were provided by nurses of the everyday experiences of threats and physical assault by patients in healthcare workplaces.

A number of respondents believed that aggression and violence had become such an everyday occurrence in their workplaces that they just accepted it, or were told by their managers that they needed to accept it because it is part of the job.

> Because I work in dementia, no action can be taken when the patients bash or verbally abuse us, they are not held accountable for their actions, nothing can be done and the workplace blames us for being attacked. (R134)
>
> A lot of the time, especially in our section, because it's classed as geriatric nursing home psych, we just get complacent and go, "That's just their normal behaviour. Who cares?" It's not normal, and being assaulted and spat on and punched at and kicked and bitten and pushed and shoved, is not normal. (C25)

While some respondents accepted patients' rights to healthcare over their rights to a safe working environment (R407), many others questioned this acceptance. For R390, *in no other job would this* [aggression] *be acceptable – if you were being rude or aggressive in a retail store or restaurant etc., you would be asked to leave*. R577 was emphatic that aggression in any shape or form should not be tolerated at any level within the hospital system – *I have been nursing a long time and over the past 10 years it has become progressively worse and more should be done to stamp out this practice*. The lack of action taken to address this aggression, the seeming preferencing of patient rights over their responsibilities, was of fundamental concern. As stated by R1:

> Aggression by patients is always allowed to go on unactioned, under the guise that they are unwell – and management states it is the nature of the job – nothing is done to deal with their behaviour – they can get away with a lot – yet staff carry the psychological and emotional burden and end up with a lot of

sick days as a way to take a break. If action was taken to bring the patient to some sort of accountability, or visible action, the patient would change.

3.2. Context of patient aggression

A significant number of questionnaire respondents and interviewed personnel highlighted three main areas with the greatest prevalence of aggression – care of older people, mental health care and emergency department (ED) settings. Of the 47 written questionnaire responses, 28 came from aged care, 13 from mental health and six from ED settings.

3.2.1. Care of older people

Patient aggression was described by some respondents as endemic in settings involving the care of older people, including in hospitals and residential aged care. An increase in dementia patients with other behavioural/mental health issues was noted by a number of nurses. Nurses described their frustration with the lack of availability of assistance from mental health services to provide advice or find more effective solutions to manage their patients with behaviours of concern. Comments were made that even in the advent of an Aged Care Mental Health referral being made, that the solutions offered were ineffective or already in place, and that there was a strong reluctance to use medications. R120, for example, asserted that:

> . . . it is preferable for a nurse to be physically abused rather than medicate a patient, I have often witnessed doctors sitting in the office, watching a nurse being assaulted and doing nothing. This has taken its toll and I no longer have any desire to be a ward nurse.

An experienced aged care nurse (R25) reflected that there now are quite serious acts of aggression from elderly confused or demented patients, stating, *I don't remember being subjected to such violence from elderly patients in the past*." C8 recalled, . . . *the patient was demented, she was elderly . . . and I was new, you know . . . you don't expect old ladies to slap you across the face*. C27 described a typical physical assault in the aged care setting:

> . . . it was a delirious old woman who hit me with her stick . . . she was going to fall over and break her hip or fracture her skull or something like that . . . and no-one else . . . I took a calculated risk that I might get hit [while preventing her from falling], and I did, but I went in knowing it might hurt . . . and it did.

3.2.2. Mental health care

A number of participants who worked in mental health care also expressed the view that physical aggression is a normal part of the work environment. For example, C27 explained about working, . . . *where you're having to sedate patients who don't want to be sedated and they are kicking out at you and you're having to help hold them down* . . . R382 noted that much of the verbal and physical violence comes from confused, delirious or drug affected patients and, while it is very frustrating getting punched, pinched, dodging biting attempts, or being yelled at, insulted and threatened on a regular basis, . . . *it seems pointless doing anything about it when the perpetrator is a 79-year-old with dementia or a person with drug induced psychosis*.

Others, however, questioned this perspective. They point out that nurses who are assaulted do not come back to work and that, on the whole, nurses leave the in-patient mental health environment after a few years. According to R22, *My workplace is dangerous – someone will end up getting seriously injured or killed. Staff are unsafe . . . We have staff regularly taken to ED with injuries including head injuries*. A rise in mental health patients affected by MDMA ('ice') was described by R53 as leading to an increase in physical assaults. For this nurse, inappropriate admissions of drug-affected patients into inpatient mental health units could be prevented by the establishment of . . . *simple legal guidelines regarding drug use and getting patients admitted* [who are] *high on drugs*.

3.2.3. Emergency department settings

Nurses working in the ED also reported a degree of acceptance about getting hurt in the course of their work. This included when providing care to patients who were either unwell, experiencing dementia/delirium or recovering from an anaesthetic. Sometimes, the characteristics of work provided an explanation for negative behaviours. C2 noted that, in the rural ED setting, there is often a lengthy wait to be assessed or treated, *I guess a combination of me and my colleagues being overworked and stressed . . . and patients waiting a long time leads to a clash, and you get that kind of violence happening*.

There was less tolerance expressed, however, for assaults sustained in the course of providing care to patients who are under the influence of drugs or alcohol. They held strong positions on the type of drug use in the community that contributes to these aggressive experiences. For R299, *in the ED, aggression and intimidation from patients/relatives/caregivers is an almost daily occurrence. I don't believe HR or senior management fully understand the extent of the problem*. This frustration was also felt by R403 who stated that, *patients in ED can treat staff with a lot of hostility and our workplace clearly states we cannot defend ourselves or our colleagues properly*. For C7, reflecting on the differences between drug-affected people presenting to the ED in Canada and Australia,

> . . . people seem to be more psychotic on meth here than they did in Canada . . . in Australia they seem to have a more prolonged detachment from reality, in my opinion. At a seminar I was taking, the presenter said it was because there is a higher purity level (84%) here in Australia than in Canada.

Relatedly, the issue of seclusion of violent people in the ED was raised as a concern by R478, who felt that the design of his ED department did not allow for the isolation of patients requiring this type of intervention. R426 made the point that although he is familiar with the guidelines in the Mental Health Act regarding restrictive intervention in cases of imminent danger, *I am being told differently by management and this concerns me as it impacts on my ability to protect myself and other people.* The frustration experienced in the context of this inherent dissonance was summed up by R203:

> I love my profession. What I cannot continue to absorb is the violence and abuse from those we are here to care for. I would like to see known offenders banned from the ED, or at least escorted by the police and charged for violence and abuse.

It can hardly be surprising that, as a result of aggression or fear of aggression, there will be some compromise in care. As C29 explained:

> You are more cautious, you are a lot more apprehensive of doing those things [connecting the blood pressure cuff]. You might be less likely to regularly do as many obs [observations] on those patients . . .. You might ask the Doctor, "This patient is too aggressive, are you happy with hourly obs?"

3.3. Co-worker aggression

While the majority of respondents were unhappy with verbal and physical aggression from patients, the majority found the incivility and aggression from their colleagues was the most distressing aspect of their work. Bullying and harassment in the workplace from colleagues or managers was a common experi-

ence of nurses interviewed in this study, and 122 respondents to the online questionnaire wrote unsolicited comments about this aspect of workplace aggression. Without exception, this was reported as having an impact on each nurse's emotional health. The comments fell into two categories – aggression from managers/supervisors and aggression from colleagues/peers.

3.3.1. Aggression from managers/supervisors

The culture of bullying was seen by some nurses as stemming from the top. As suggested by C21, . . . bullying and harassment – that starts at government level, at ministerial level, then it filters down to the CEO, then the CEO sends all that down through the different layers of management. R71 wrote that she had experienced and witnessed workplace aggression many times and that . . . 99% of the time it derives from upper management, who get away with abusing and threatening employees and never seem to be reprimanded or stood down from their position. Aggression and intimidation from senior staff and upper management is . . . a daily issue (R547). For R580, . . . most workplace aggression comes from management not the patients or the public, while others were united in their belief that it is hard to get support from your manager when, as reported by R530, . . . they encourage and participate in the bullying and intimidation. Sadly, R92 reported that, . . . in my seven years of experience, I have always experienced workplace intimidation from my senior nurses, I have come to accept it as a daily part of the hospital culture, but I plan to leave hospital nursing for good as there is not much more I can take.

Some nurses were cynical about the leadership capabilities of their immediate managers. As C21 indicated, . . . nurses should have psychological testing before being given management roles to avoid being the two faced manager, one for staff and one for senior management. C25, on the other hand, suggested that support from managers has always only been . . . to cover their own bum. R657 stated that, . . . the worst thing for me was seeing my colleague being bullied by my manager.

Managerial nepotism and collusion were also key concerns expressed by interview participants. For example, C15 observed that there was a lot of friendship between the manager and the person perpetrating the aggression, while C16 noticed that the managers . . . *do this sort of bullying . . . befriend the other managers . . . all similar personalities*. Further, C19 felt that the managers tended to look after the people they wanted to look after, and . . . *everyone else had to wear it . . . they protected certain people and the rest of us were obviously not valuable enough.* C26 stated that, in her opinion, managers are being taught how to manage other staff out structurally . . . *you can complain but it will come back to bite you or you will be ostracised in many ways and bullied out of your job or demoted.* C23 stated that she did everything by the book in reporting her manager to her superiors – yet, . . . *my manager was promoted*! C14 related that if the managers in her facility found out that a staff member had put in a complaint, . . . *they'll get rid of you . . . one of the girls who is management said, 'no-one will report me for bullying. Basically, I'll come after you if you do'.*

Human Resource (HR) departments and personnel were generally viewed as unhelpful and on the side of hospital administration. In some instances, nurses felt that raising issues further up the management chain was too risky because of individual ramifications. C1 gave the example of what happened to him when he raised an issue with his manager: *Senior management threatened me with reporting me to HR because I had raised a professional query about a policy issue – she could destroy my career!* C3 said, *You can't go to HR (about staff aggression), it's common knowledge.* C2 agreed, saying, *HR is not good when dealing with staff conflict.* C26 was very dissatisfied with her attempts to deal with stressful work issues via HR personnel: . . . *a 35-year-old idiot! . . . when I told other nurses that I was seeking assistance with HR, they said 'good luck with that'.*

3.3.2. Aggression from colleagues/peers

Bullying from colleagues/peers was expressed mostly as insidious comments about performance, undermining and ostracising. As stated by C11, . . . *you always feel that you're less than, that you are under par, that you've never done well enough.* Recounting their experiences was quite emotional for some nurses. For example:

> I've been bullied very, very badly. I'll probably cry . . . I have reported it but it's gone nowhere . . . Aggression from a colleague has affected my health and well-being massively ... when you can't go to work and feel confident . . . yeah . . . hurts your feelings quite a bit." (C13)

Many nurses questioned their ongoing commitment to nursing when they have experienced aggression in their workplace. As C25 recalled, . . . *it got to the stage where I was making myself physically ill because of the stress of knowing I had to go back to work, and the bullying that was going on from my work colleagues.* For C16, . . . *if you don't have a happy team and you have staff members that give you a hard time, it's enough for you to leave nursing.* R6 stated that she felt bereaved for the workplace (compared to how it used to be): *I feel scared, unsupported, miserable, I hate a job I used to love.* C19 recounted, *I get anxious – with my new job I get concerned if they're going to be similar personalities at work – it has affected my nursing care quality – thoughts have come to me to get out of nursing altogether.*

As highlighted above, levels of distress remain high, despite campaign after campaign by governments and professional bodies aimed at addressing bullying in the workplace. Nurses and midwives are cynical about anything changing when they feel that they work in toxic workplaces. For many study participants, if bullying behaviour is part of the organisational culture, then it is seen as almost impossible to change. No-one stands up to the bullies, with their behaviour often being excused, that they are . . . *a rough diamond* . . . (R547), or they are told to accept the bully . . . *for who she is – don't rock the boat* (R343).

3.4. Reporting behaviours

It is very clear from the interviews that reported incidents of aggression are just the 'tip of the iceberg'. In the State of Victoria, the majority of nurses and midwives report incidents using the Victorian Health Information Management System (VHIMS) (Victorian Agency for Health Information, 2018) or Riskman (2018) systems. These organisational reporting systems were strongly disliked by interviewees because of the complexity and the length of time required to complete incident reports. Feelings regarding the usability of VHIMS were summed up by C1: *I've never seen a more complicated form in my life ... You sit down with this bloody form and you're there forever and you just loose the will to live.* For C4, . . . *VHIMS is probably the worst piece of software ever written anywhere in the world, I would think, without any fear of exaggeration.*

The onerousness of reporting using current systems was a key barrier. As expressed by C17, . . . we don't do incident reports unless the aggression is getting really serious. It takes too long – 40 min. For C7, I only report it when I get hurt because the reporting system is really lengthy. It takes a long time to actually register [the report]. Additional factors included the recurrent and frequency of aggressive behaviours – You don't always report, I get jaded . . . there are a couple of things that I tolerate, that I shouldn't (C27) – a belief that there was no point in reporting because, . . . nothing is ever done (C28), and disillusionment with the lack of follow up – I filled out . . . incident form[s] of cases of patient aggression and it seems to have gone into a big black hole, never to be heard of again (C12).

Respondents gave often disturbing accounts of their experiences of aggression and violence, but the majority indicated that only the more serious incidents of aggression, primarily physical aggression, were reported. As C15 stated, *I only report when it is bleeding and it needs to be dressed*. Despite the seriousness of the incidents that nurses and midwives experienced, however, many did not report at all. The basis for non-reporting included lack of knowledge about the purpose and scope of the reporting systems. For example, C20 offered, . . . *VHIMS, that's for patient safety isn't it? I wouldn't report incidents – I feel it is a nurse's job to just absorb it . . . I feel like we need to be a bit thick-skinned*.

Verbal aggression from managers or colleagues was very rarely formally reported, despite the distress this behaviour caused. In an effort to avoid continued contact with unpleasant colleagues, nurses described a number of strategies they put into place to avoid the person, where possible.

I stay on the casual roster as this offers me the ability to refuse work when rostered on with the staff in question (R208). I have decreased my hours to avoid working with 2 or 3 staff members who can be very undermining to me (R473) or, It is easier as a casual nurse just to be unavailable for that particular ward (R251).

Study participants working in regional areas pointed out that raising unpleasant issues in the workplace could cause much deeper problems for them, as highlighted by C2: *I'm in a situation where the hospital is the largest public employer in the area, so there is not much ability to move around to get away from potentially toxic people* (C2). Similarly, for C11, *I have not reported incidents of . . . aggression from fellow staff members because I live in the rural area that I work in. If things became really difficult at work, then that limits my choice if I had to leave ... I'm too scared.* C25 stated that reporting bullying just makes the whole situation worse and that you would be labelled, ". . . *a dobber, and then nobody talks to you*.

A final note on reporting behaviour is that WorkSafe (the Victorian work health and safety authority) was rarely mentioned by respondents as an alternative for reporting incidents of workplace aggression. Nurses generally seemed unfamiliar with the role that WorkSafe could play in relation to exposure to the hazard of workplace aggression and often confused WorkSafe with WorkCover (the insurance arm of WorkSafe). One respondent (C29), however, described that:

> They [the employer] gave me an option of going through WorkCover but they strongly suggested against that. My Union rep really wanted me to go through WorkCover. At that stage I was that distressed and upset, the way they [the employer] portrayed what could happen, that I could be pulled through the ringer with going to appointments in Melbourne, getting psychologically assessed. It could be a drawn out process. They [the employer] gave me an option of having our own mini return to work plan.

3.5. Trade union involvement

Respondents expressed a variety of opinions about the support received from the ANMF-Vic. In general, trade union support was understood to be in the form of advocating for wages or conditions and generally not as helpful in the area of aggression from colleagues or managers, although this did vary. C23 felt that the union . . . *had no power. You literally had to beg them for assistance and follow-up*. In her experience, communication and follow up needed to be much better. C28 involved the ANMF-Vic in her case, but found that it made no difference. C3 thought that the Union was too close to HR and worked . . . *in collusion with management.* C25 described the intervention of the ANMF-Vic as a ". . . *pissing contest between them and management.* C18 did not think she would involve the Union as she wondered whether they would support her or support the person causing the aggression. C27 was unhappy there was no Union presence for those nurses working permanent night shift, stating . . . *they work ladies' hours, but health is a 24 h, 7 days a week industry*.

In contrast, other participants spoke highly of the support they received from the ANMF-Vic. C16 stated that, *Support from the Union was fantastic. Should have done it earlier.* For C17, *The ANF* [ANMF-Vic] *were very good in dealing with vexatious accusations in the workplace.* C26 described contacting the ANMF-Vic and spoke very positively of the help provided: *I wasn't in the ANF* [ANMF-Vic] . . . *but I did ring the Union and they were on my side and were very supportive.*

3.6. Security personnel and police involvement

Physical aggression in health care facilities is predominantly managed by calling a 'Code Grey' in larger hospital facilities, calling security services who may be off-site and who cover a number of smaller facilities, or by calling the police in more rural or remote areas. Police are also called for a 'Code Black' in the case of more serious security incidents. In general, it was reported that the police are reluctant to press charges against patients who physically assault nurses and midwives. The common reason given is that, because the patient has either a mental illness or is under the influence of alcohol or other drugs that, by the time it gets to court, charges will be dropped or it will not result in prosecution. For example:

> I have called the police – the person was threatening they were going to kill staff members and harm others – but the police said because nothing had happened yet, they weren't going to come down. (C15)
>
> I was hit by a patient recently – we called the police but they never turned up, so I was just kicked and punched and whatever by the patient – we rang the police several times because this was getting very physical, and they never arrived. (C17)
>
> There is little support for staff to take an incident of physical threats/violence by patients to the police – they state that the charges are a 'waste of time' as it will be thrown out of court by the magistrate due to the patients' diagnosis. (R36)

While nurses are extremely appreciative of the presence of security personnel in their facilities, security personnel were also seen as untrained and ill-equipped to appropriately and skilfully deal with incidents of aggression. *Security ... don't do anything, they just stand and watch . . . they don't have enough training* (C25). In some cases security can exacerbate a situation. As described by C27, . . . *security can overstep the mark by interjecting when they should be quiet – I've had to take them aside to talk to them.*

3.7. Legal action

Comments in the free-text field of the questionnaire relating to taking legal action were provided by 368 respondents. Comments were also provided by every in-depth interview participant. Respondents rarely engaged legal services following experiences of verbal or physical aggression for a number of considered reasons. There was a strong feeling that there was no point in pursuing legal action. A considerable number expressed the belief that pressing charges in the case of a physical assault was a waste of time because the patient was under the influence of alcohol or other drugs, or had a mental illness and that charges would be dismissed. For example, R371 described an assault in ED: *I was strangled by a patient with psychosis and looked into charges against my employer but was told by WorkCover and the Union that, as there was no permanent physical damage, I was unable to*.

Participants also expressed the belief that it was too costly a process to contemplate taking up legal action against perpetrators

of aggression, financially or from an emotional point of view. For example, R345 stated, *I have witnessed other co-workers take legal action against patients at work, nothing ever happens to the offenders, not one person has ever been convicted of a crime for assaulting a health care provider.* A further reason for why respondents would not take up legal action was because of the fear of retribution or of losing their jobs. For R364, for example, *Too scared to bear the consequences of my investigation, already suffering enough.* Or, for R370, *Why bother, I would lose my job.*

Participants living in rural or regional areas, where people in the health industry tended to know each other, felt strongly that their privacy could not be maintained. As explained by R270, *To take legal action would be the death of my professional life ... even if I did win, I would be blacklisted and unable to get any work.* On the other hand, when C26 brought in a family friend who acted as her solicitor, it had an immediate positive impact on managing a hostile management, who she felt were unfairly trying to dismiss her: ... *when I said I was coming in with legal – well then they said 'oh well, just to clarify, this is not going to result in a dismissal of your job'.*

3.8. Impacts of workplace aggression

Some study participants reported significant negative impacts on physical and mental health following as a result of exposure to workplace aggression. For example, R560 revealed, *I am frightened of people, I am experiencing situational anxiety disorder, clinical depression, disassociation and traumatised syndrome.* For C28, *I have increased blood pressure and anxiety*, while R414 stated, ... *this workplace has given me heart palpitations, anxiety and skin rashes.* R397 recounted a loss of confidence, ... *in everything, myself, my capabilities. I now have cardiac problems and high blood pressure.* Mental health issues, however, were more predominantly reported, particularly anxiety, depression and substance misuse.

Respondents also described experiencing post-traumatic stress disorder (PTSD) and suicidal ideation, needing psychiatric as well as psychological intervention. For example, R3 stated that, ... *in my 26 years of nursing I have witnessed 3 colleagues commit suicide as a result of bullying and workplace pressures – not once has anything been done to address what happened.* For C25, *I had to take 12 months off work because of the bullying and I tried to take my own life.* R265 revealed being admitted to the ED for a suicide risk assessment following bullying from a nurse preceptor while on clinical placement. The potential extent of the impact of workplace aggression was described by R39:

> The physical and emotional toil was so great I resigned without a job to go to as I just couldn't bear it anymore and I am the 6th person that I know of who has left my workplace ... nothing has been done to address the issue.

4. Discussion

It is evident from the results of the analyses of free-text comments by respondents to the online questionnaire and the content of the in-depth interviews, that there is a simmering undercurrent of resentment, anger, anxiety, sadness and stress resulting from exposure to workplace aggression in Victorian health and other care settings. Respondents reported frequent physical assaults by patients in their care, particularly in aged care, mental health and ED settings. They reported high levels of exposure to acts of aggression from co-workers and managers, and described a range of physical and emotional responses to these incidents. They expressed feelings of powerlessness to take action either through the organisational systems and processes or through legal channels.

Thirty-four years after the publication of the seminal Australian study by Holden (1985), examining the causes and effects of aggression toward nurses in Victorian hospitals, it is clear that the situation has not improved. On the whole, nurses, midwives other care personnel have trained and work to provide assistance to people who are unwell and require care. The expectation that this will be appreciated by the recipient of care is inherent in the transaction of providing and receiving care. That they are then abused or attacked while performing this role leads to a sense of resentment and disillusionment. Holden (1985) described the dissonance experienced by nurses who want to nurture the very patients they are afraid of as, "... wanting to help yet feeling helpless" (p 46). In the current study, so many who were interviewed or who recorded free-text comments were really pleading for something to be done to address this issue. Indeed, the question that must be asked is, can it be considered acceptable to continue investigating this critical work health and safety concern for another 30 or 35 years with no improvement in the safety and well-being of care providers being realised?

While nurses, midwives and other care personnel may have, in the past, put up with a certain level of aggression and violence in their work, this tolerance is changing. This is evident both from comments expressed through the study interviewees and respondents, and by the greater public awareness and renewed focus on exposing and identifying violence in the community, exemplified by the #MeToo movement. Many respondents expressed the view that assaults by patients need to have consequences, such as prosecution, regardless of whether the patient is intoxicated, drug affected, delirious, psychotic or frustrated from waiting long periods. Nursing and midwifery, in particular, need either to be declared as dangerous professions, so that it is clear that people working in these professions must expect to experience verbal abuse and physical assault on a regular basis, or significant and wide-ranging structural changes must be made to prevent and minimise the high levels of risk. Levels of exposure and impacts have not changed, and many of the strategies recommended or employed to prevent or minimise workplace aggression seem not to have worked (Hills & Joyce, 2013; Hills et al., 2018).

High rates of verbal aggression from colleagues and managers were reported in this study. The constant low level rudeness and harassment that many respondents experienced has been investigated in the body of work examining incivility. Incivility has been defined as "low-intensity deviant workplace behaviour, with ambiguous intent to harm ... [which is] ... characteristically rude, disrespectful and discourteous, displaying a lack of regard to others" (Andersson & Pearson, 1999, p. 454). Incivility ranges from not being helped by colleagues when the workload is heavy to belittling in front of others, rolling of eyes or not being included in social events. New graduates seem especially vulnerable (Mammen, Hills, & Lam, 2018). Wressell, Rasmussen, and Driscoll (2018) assert that nurses who are constantly exposed to incivility and aggression become desensitised, and fail to recognise the effect on themselves and the way that nurses interact with each other. Feelings of anger and frustration can then be internalised and displayed as irritability or incivility.

One perspective is to consider this phenomenon in terms of oppression theory. Mikaelian and Stanley (2016) put forth the view that nursing is a doubly oppressed group, firstly in terms of medical domination and secondly in terms of gender. Matheson and Bobay (2007) argue that oppressed groups, such as nurses, become submissive in the presence of their oppressor and a pent up resentment is released in the form of retaliation towards their fellow oppressed. As such, oppressed group behaviour does not effectively challenge the issue of incivility, thus incivility becomes normalised. Hutchinson, Vickers, Jackson, and Wilkes (2006), however, caution against the continued use of the 'oppressed group' model to explain

co-worker aggression for, to do so, focuses attention only on the behaviour of nurses and draws attention away from work environments that condone and perpetuate abusive practices. Certainly, the experiences reported in the current study can be recognised as deriving from issues of entrenched culture, spanning across organisations and specific workplaces, and across generations.

The cultures of health organisations contribute to the overall feel, function and direction of an organisation (Day & Marles, 2015). Regardless of size or whether government funded, for profit or not for profit, organisations are shaped by a range of forces such as State and Federal regulations and pressure from other agencies – such as equipment manufacturers and pharmaceutical companies – and even physicians (Payne & Leiter, 2013). Organisational behaviours require walking a fine line between ensuring best practice care and the costs associated with this mandate. If senior managers, who may not have a clinical background, impose unrealistic performance targets on their staff, then discontent can trickle down to front-line staff and create a dissonance. Patients and care providers want high quality services and care. Managers are required to manage expectations within financial and other resource constraints. The tension that this creates in the layers of management may be reported by nurses as uncivil and bullying behaviours. It can start right at the very top, and enable incivility and bullying behaviours to go unchallenged. Importantly, organisational incivility and aggression impacts not just on staff members, but also on patient care, staff retention and organisational reputation (Mikaelian & Stanley, 2016).

In the current study, respondents reported needing to quickly adapt to the prevailing workplace culture or leave. Those who challenged the workplace behaviours or who did not assimilate quickly enough were subjected to a range of uncivil behaviour. The common refrain of "my way or the highway" is given if a nurse questions a policy or a protocol. Unprofessional behaviour from fellow colleagues is excused as "she's a plain speaker, or 'her bark is worse than her bite'". This incivility in the workplace is deeply entrenched. It is eroding the nursing work force with more and more nurses leaving fulltime work due to ongoing, substantial unhappiness in their workplace. Unprofessional behaviour or the incivility evident in workplaces reported on in this paper highlights the urgent need for leadership at the highest level to tackle this issue.

Another important consideration concerns generational attitudes. As previously reported (Hills et al., 2018), the age of respondents in this study ranged from 22 to 77 years. Potentially, there could be four generations in a workplace, each with its own prejudices and perspectives. Although not a focus of this study, a small number of respondents made comments either dismissive of older clinicians, viewing them as unable to use technology and fixed in their ways, or critical of younger clinicians, who were viewed as lacking emotional maturity. These generational attitudes can lead to misunderstandings and contribute to unprofessional behaviour. Research examining generational characteristics and behaviours can provide valuable insights into realising the potential of nurses, midwives and other care personnel across the age span. For example, Christensen, Wilson, and Edelman (2018) describe Generation Z as the most diverse yet, but generally require novel approaches by nurse leaders to stay engaged and productive. At the other end of the generational spectrum, baby boomers tend to enjoy being a mentor, while millennials seek constant mentorship. Generation X enjoy individual challenges and are self-directed, making them ideal for solving clinical practice issues. Millennials are viewed as good resources for rolling out initiatives, while Millennials and Generational Z, with their strong connectedness and capabilities with technology, can be used to support members of the team who need help (Christensen et al., 2018).

5. Limitations

In this pragmatic, descriptive, qualitative study, thematic analyses of combined responses from 623 survey participants who provided commentary in free-text boxes in an online questionnaire and from transcripts of interviews with a purposive sample of 29 survey participants. While the analyses drew on the perspectives of a large sample of the population, no claim is made that the responses are representative of the population of nurses, midwives and care personnel in the State of Victoria, across the Commonwealth of Australia, or internationally.

6. Conclusion

Exposure to workplace aggression is inherent in the work of Victorian nurses, midwives and care personnel, and there appears to be have been little progress in mitigating the likelihood and consequences of this highly concerning work health and safety, and public health issue. Almost 35 years ago, Holden (1985) provided a set of 10 recommendations to address what has become an entrenched and even worsening problem for clinicians and support personnel. On the whole, these recommendations are reflected in the Australian Nursing and Midwifery Federation policy on preventing workplace aggression and violence (Australian Nursing & Midwifery Federation, 2018). Further, comprehensive employer guidelines provide explicit details on how to prevent and minimise workplace aggression in health care settings in accordance with current work health and safety legislation (WorkSafe Victoria, 2017). While the evidence for interventions may be equivocal, it is likely that it is the failure to implement co-ordinated, multi-sectorial, system-wide and targeted interventions, with appropriate levels of accountability and enforcement, that perpetuates the growing levels of harmful exposure to incivility and aggression in care settings in Victoria (Hills & Joyce, 2013; Hills, Joyce, & Humphreys, 2013; Hills et al., 2018).

Deep, difficult and complex changes need to be made, including in relation to strengthening and enforcing existing legislation and introducing new laws that adequately protect the health and safety of nurses, midwives and other care personnel in their work. Civility needs to be established as the norm in health care. Managers need to be able to provide and receive constructive feedback on performance. More innovative mechanisms are required to enable health personnel to report incidents of aggression, and to prosecute sanctions for transgressive and criminal behaviours. The constructive engagement of patients and their advocates in co-designing more person-centred health services is also likely required. Finally, stronger evidence for system and service level interventions to prevent and minimise workplace aggression in care settings needs to be developed. This will necessarily require sufficient investment in more rigorous research into this significant professional and community health and safety concern.

Conflict of interest

None.

Ethical statement

The conduct of the study was approved by the Monash University Human Research Ethics Committee and conformed to the National Statement on Ethical Conduct in Human Research 2007 (National Health & Medical Research Council, 2015).

CRediT authorship contribution statement

The paper properly credits the meaningful contributions of co-authors and co-researchers.

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