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Covert violence in nursing: A Western Australian experience

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USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

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DECLARATION

I certify that this thesis does not, to the best of my knowledge and belief:

(i) incorporate, without acknowledgement, any materials previously submitted for a degree or a diploma in any institution of higher education;

(ii) contain any material previously published or written by another person except where due reference is made in the text; or

(iii) contain any defamatory material.

ABSTRACT

Covert violence in the workplace has been extensively theorized amongst social scientists as having negative effects on the worker's self esteem, job satisfaction and stress, resulting in increased absenteeism and a reduction in productivity, and yet it continues to fester in nursing.

The purpose of this research was twofold. The first was to answer the question, 'What are the characteristics of covert violence experienced by Western Australian nurses?' and through the description of Western Australian nurses' experience of covert violence and describe the characteristics related to this to form a definition of covert violence. The second question was 'What are the causes of covert violence experienced by Western Australian nurses?

This study explored nurses' experiences of covert violence using an interpretive phenomenological approach as described by van Manen (1997). A literature review was conducted to establish the findings of studies in relation to covert violence in other countries and to compare similar works in Australia. Using literature review findings, interview questions were designed to identify episodes of covert violence amongst nurses, the background to the reported events and a comment by the participants as to how these episodes were dealt with. A proposed model of the causes of covert violence in nursing was developed from the literature review to be tested in relation to the research findings.

Research participants were all Registered Nurses with the Nurses' Board of Western Australia who were asked to identify and discuss their experiences of covert violence in their workplaces. The data collected was analysed using pattern matching for qualitative evaluation.

Results obtained from the data analysis identified the most important factor leading to covert violence was the juxtaposition of power and powerlessness and how it was influenced by community expectations of healthcare, staffing and client characteristics, infra-staff issues and management systems.

Based on the research findings a revised model of causes of covert violence was developed to identify how power and powerlessness affect the outcomes of patient care, staff morale and the ultimate retention of staff in the health service in particular and in the profession generally. To record the incidences of covert violence and how they can be dealt with, a risk action plan and a model of obligations to prevent covert violence in nursing was developed that would not only serve its purpose in the nursing profession. From these questions it was possible to develop a Risk Control Action Plan that can be applied in response to reports of covert violence and to prevent covert violence in the nursing workplace, and can be adapted to address a similar situation in any other workplace. The tools developed include ways of reducing patient stress, methods of improving staff relationships, and management tools for issues that need to be addressed by nurses and administrators. Recommendations for further research to extend this study and to test the covert violence prevention tools developed as a result of this research are made.

It is anticipated that use of the revised model of covert violence in nursing, definition of covert violence and tools developed as a result of the research findings will minimise incidences of covert violence, resulting in greater job safety and satisfaction for nurses, a reduction in staff absenteeism due to job stress, and an improvement in nursing retention and productivity.

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Covert Violence – A Western Australian Experience

1.INTRODUCTION

1.1. Introduction

This chapter introduces the thesis and provides detailed background to, and justification for the study. It begins with a general background to the topic of covert violence in nursing and details the reasons for this current research.   It highlights the global context of covert violence and sets up a framework for the research study.

1.2. Background

Nursing is a dangerous occupation! Every year there are countless injuries attributed to the lifting, moving and repositioning of patients, falls, trips, needle stick injuries, the risks of infections and cross-infections as well as of assault (SafeWork Australia, 2011). These episodes are almost always recorded and dealt with appropriately, but one element of danger and injury that is not given full notice is that of covert violence.   Mayhew and Chappell (2001) cite The European Foundation's figures as being at least 2% of nurses are subjected to *physical violence* and an English study (Quine, 1999) cites up to 42% of nurses are subject to *internal or covert violence* at the workplace. In these cases, whilst no physical injury is sustained, the effects of covert violence such as verbal abuse, job and physical threats and intra-staff hostility can have permanent repercussions such as low self esteem, and can rob nurses of their time, energy and devotion to their profession.

Historically, this workplace situation was regarded as the norm, with the focus placed on the patients, their care, their families and other staff. A nurse was expected to be mature and professional enough

not to be affected by abuse and harassment. It was all 'part of the job' and if a nurse could not cope with the stress, then she was considered unsuitable to stay in the profession.

The view of covert violence has changed in the 21st Century to the extent that it is no longer acceptable for patients, their families or other staff to harass or abuse a staff member regardless of the situation. In line with the United Nations Human Rights Declaration (2000), the Western Australian government has clearly outlined the duties of an employer in the Western Australian Occupational Health, Safety and Welfare Act 1984 Part 3, Section 19(1):

> 'An employer shall, as far as is practicable, provide and maintain a safe working environment. An employer should:
>
> 1. provide and maintain workplaces such that …his employees are not exposed to hazards;
> 2. provide such information, instruction and training to his employees to enable them to perform their work…and that they are not exposed to hazards;
> 3. consult and cooperate …regarding occupational health, safety and welfare in the workplace.

With the implementation of this Act, a safe working environment is no longer a privilege, but a right. Nurses should be able to work in a violence-free environment, but this is still to become a reality. Despite studies and surveys conducted around the globe, this issue of both overt and covert violence against nurses continues, not only to just exist, but it is actually on the increase (Johnston, Phanhtharath and Jackson, 2009).

1.3. Previous Research

The first research into covert violence against nurses was published by Roberts in 1983 – it involved details about workplace bullying in the United States of America (U.S.A.). Other research studies that identify covert violence occurring in nursing include research from the United States of America, [Spring and Stern, 1998; Lybecker, 1998;

Johnson, Phanhtharath and Jackson, 2009; Johnson and Rea, 2009; Skillings, 1992; Furlow and Bushby, 1998; American Nursing Association, 2011;] Canada [Hesketh, et al., 2003; Henderson, 2003; Canadian Nursing Advisory Committee, 2002; Ulrich and Lavendero, 2006; Registered Nurses Association of Nova Scotia, 1995], Britain [Alderman, 1997; Orlovsky, 2005; Kulwicki, 2000; Gilmore-Hall, 2001; Aiken et al., 2001; Sofield and Salmon, 2003; "Bully OnLine", 2004; Purchase, 2004; Lewis and Orford, 2006; Zuzelo, 2007; British Broadcasting Corporation (BBC), 2002; Ryan and Maguire, 2006; Alexis, Vydelingum and Robbins, 2007] and Australia [Hastie, 1995; Fisher etal., 1995; Leap, 1997; Farrell, 1997; Queensland Nurses' Union, 1998; Hockley, 2000; Mayhew and Chappell, 2001; Taylor and Barling, 2004; Farrell and Bobrowski, 2006; Martin, Gray and Adam, 2006; Martin, 2008; Hutchinson, Jackson and Wilkes, 2010; Alspach, 2007; Lea and Cruickshank, 2007; Gillespie, Wallis and Chaboyer, 2008; Prior, 2008; and Tillett, 2009], Switzerland, [International Labour Organisation, 1998; 2000].

There are also studies from Turkey (Uzon, 2003), New Zealand (McKenna et al., 2003), South Africa, [Steinman, 1997; Steinman, 2003], from Sweden, [Josefsson et al.. 2007; Tragno, Duveau, and Tarquino 2007] from France, Oweis and Mousa, (2003) from Jordan, and Einarsen, (n.d.) and Einarsen and Skogstad, (1996) from Norway. All affirm the prevalence and devastating effects of covert violence in the nursing workplace.

Johnston, Phanhtharath and Jackson, (2009) from the United States of America continue to show that covert violence in hospitals and medical centres is on the rise, more nurses are reporting it, and yet little is being done to ease the problem. In some health services, despite there being a written policy displayed in most public access area, covering situations such as physical violence due to drunkenness or drug use, there is no inclusion of covert violence issues such as offensive or abusive language, threats to staff safety or security, or intra-staff bullying and harassment.

In a qualitative research study of covert violence in a Western Australian hospital (Bakker, 2003), forty registered nurses responded to questions regarding their experiences of covert violence in their workplace. Several respondents stated that they were becoming tired of being abused and that management did not appear to support their right to a safe working environment because of the negative reactions given to the report of such abuse. These nurses were prepared to look for work other than nursing if the situation did not change.

 This correlates with an American study by Johnson and Rea (2009) of 249 registered nurses, 27% of whom had experienced workplace bullying in the previous six months and because of this a third of nurses who reported being bullied at work were twice as likely to leave their job, and indeed three times as likely to leave nursing altogether.

Dellasega (2009) concludes from her research that horizontal violence or bullying from colleagues occurs especially to new graduates, to those who are promoted or who receive honours that colleagues consider undeserved, to those who appear to receive special attention from their seniors or from physicians and occurs often when the wards or units are severely understaffed.

The results of covert violence are far-reaching. Nurses who are bullied are less compassionate (Randle, 2003), and report that they are more likely to make errors in treatment (Farrell and Bobrowski, 2006) and Rutherford and Rissel (2004). Johnson (2009) adds to this by reporting that general customer care and safety for both staff and patients may be jeopardised.

Although of great importance, covert violence remains under-reported. Freire (1971) theorized that this is because dominated people feel devalued in a culture where the powerful promote those who abide by the valued attributes of the culture – in this case

nursing. Only those who support this dominant view are rewarded with promotion and honours. DeMarco etal., (2007) agrees and adds that silence about covert violence in nursing is thought to be a strategy to avoid further conflict and to maintain the status quo in the workplace and in the private lives of the nurses involved. Johnson, (2009), however, suggests that it adds to the underlying stress of the work-place resulting in the social isolation and ostracism of whistleblowers, their perception of job satisfaction, and can ultimately exhaust their outside support networks (Lewis and Orford, 2005). Johnson (2009) also notes that even witnesses to workplace covert violence may experience stress themselves and feel powerless to intervene.

Therefore a true zero tolerance policy is wanted by nurses and is required by Occupational Health and Safety Act, 1984, (Western Australian Occupational Health, Safety and Health Act, Part 3, Section 19 (1)), but for many health centres, this is not reality. Covert violence is still a neglected, often denied issue, both by management and by nurses themselves. Mee (2003) reported that nurses want management to have a zero tolerance towards abusive behaviour that harms individuals or groups. This would encourage nurses to feel valued and to be able to perform at their optimum level and develop professionally. Nurses are often reluctant to report such incidences due to fears of management 'retribution' or simply the loss of the job. It must be addressed in order to prevent the continuing devaluation of, and loss of nurses from the profession.

This research sought to identify examples of covert violence in Western Australian hospitals and worksites, some of the issues involved in the situations identified, and to offer workable solutions in order to make the task of nursing less stressful and more rewarding. If Nursing is to attract and hold new 'recruits', then it must be an occupation which is seen as valuable and safe. This research was conducted to address this 'value' of nurses by acknowledging nurses' concerns about covert violence they have experienced and to

respond positively to the problem by reducing, as far as possible, episodes of covert violence.

1.4. Purpose

The purpose of this research was to identify and discuss types of covert violence and their causes that have been experienced by registered nurses in Western Australian healthcare centres.

1.5. Definition of Terms

In order to facilitate this research, a definition of 'covert violence' was necessary. There is no one central definition of covert violence. British articles such as Alderman, (1997, p23) refer to 'covert violence' but American and Canadian literature seem to concentrate on 'horizontal violence' (*Nurse Advocate*, 1998b). *Nurse Advocate*, (1998a, p1) describes six types of covert violence directed towards nurses. They are:

1. Bullying, intimidation, belittling;
2. Inappropriate or unwelcome physical contact;
3. Sexual harassment;
4. Elitist behaviour based on education or area of practice;
5. Unacceptable language such as swearing; and
6. Management practices such as understaffing, disregard for staff safety or mental or physical health.

There are articles from the Queensland Nurses' Union (1998), Lybecker (1998) from the United States of America and Spring and Stern (1998) from Canada all highlighting different aspects of covert violence. Regardless of the term used, they all refer to unrecorded, non-physical abuse of nursing staff.

The Australian Concise Oxford Dictionary (Fowler and Fowler, 1987, p237) defines 'covert' as something 'secret...hidden...disguised threat or glance' and 'violence' as being 'violent conduct or treatment, outrage, injury…unlawful exercise of physical force, intimidation or

exhibition of this.' The types of violent episodes researched in this study were, indeed 'hidden…disguised.' There was no official method of reporting them, therefore they could be denied by staff and management in an effort to down play their effects on staff.

'Horizontal violence', a form of covert violence, is defined by Skillings (1992, p180) as being a 'form of internal fragmentation of oppressed groups'. It results in an attitude of acceptance on behalf of nursing staff. It belongs in what Freire terms a 'culture of silence' (1972, p167) which just perpetuates the problem. The silence is exacerbated by the feelings of helplessness and belittlement, fear of being branded a 'troublemaker' and of losing the job itself.

Nurse Advocate Forum (1998a, p1) defines horizontal violence as 'harmful behaviour, via attitudes, actions, words, and other behaviours that are directed towards us by another colleague…(It) controls, humiliates, denigrates or injures the dignity of another…(It) indicates lack of mutual respect and value for the worth of the individual and denies another's fundamental human rights.' Thus horizontal violence is a special form of covert violence, rarely reported yet powerful in its short- and long-term effects.

Proactive Nurse, (2004, p1) defines horizontal violence as 'activities that cause humiliation or injures the dignity of another...It indicates a lack of mutual respect and value for the worth of the individual and denies another's fundamental human rights.' Spring and Stern (1998, p1) defines it as 'behaviour that we direct toward each other that would be totally inappropriate if we directed that same behaviour, action, word, tone, attitude, judgement towards a patient.'

Another form of horizontal violence is bullying. This occurs when '…one or several individuals persistently over a period of time perceive themselves to be on the receiving end of negative actions from one or several persons, in a situation where the one at the

receiving end has difficulties in defending him/herself against these actions.' (Einarsen et al., 1994, p20)

So, for the purpose of this study, 'covert violence' will refer to any non-physical abuse such as a specific behaviour, look, action, humiliating or belittling act that distresses a nurse in the process of her/his work.

1.6. Research questions

This study was designed answer the following questions:

- What are the characteristics of covert violence experienced by Western Australian nurses?
- What are the causes of covert violence experienced by Western Australian nurses?

1.7. Outline of the Thesis

Chapter One has described the background to this study, why it was undertaken, previous studies on related topics, and provides a broad overview of 'covert violence'. It also outlines the reasons why this issue is of major importance to staff retention, dignity and safety in nursing.

Chapter Two is dedicated to a literature review which outlines the broader context of the field of study, the theoretical underpinnings and the main contributions of research to knowledge of covert violence, particularly for nurses. It covers information from Australia, New Zealand, the United Kingdom, Canada, the United States of America and other countries where covert violence in nursing has been identified. It also includes literature written on covert violence experienced in other occupations.

Chapter Three presents the fundamental methodological decisions and approaches for the present study. The qualitative design is

discussed and examined for its relevance in this study. Details are given regarding the recruitment and sampling methods and the measures taken to ensure validity and reliability of the research findings. Included are descriptions of the research methods, the data analysis process and ethical considerations.

Chapter Four answers the two research questions. They are:

- What are the characteristics of covert violence experienced by Western Australian nurses?
- What are the causes of covert violence experienced by Western Australian nurses?

It presents a summary of the participant nurses' perceptions of incidences of covert violence they have experienced in their workplaces.

Chapter Five critically reflects on the most important findings and looks at the dichotomy of power and powerlessness, and obligations each group of perpetrators must fulfil in order to limit the adverse effects of these two concepts.

Chapter Six discusses the research conclusions in relation to answering the two research questions. Recommendations for risk control measures to be used to reduce the incidences of covert violence in nursing are documented. A model of obligations of patients, clinical nurses, management and medical practitioners to prevent covert violence in nursing has been developed and is displayed. Opportunities for further research in relation to the prevention of covert violence in nursing are identified.

This study has made an original contribution to improving the discipline of nursing through identifying causes and risk control factors for covert violence in nursing. It will substantially contribute to the field of evidence-based knowledge about the causes and mitigating factors for covert violence in Western Australian nursing.

Findings of this research will impact positively on nurses' professional practice worldwide because the causes and risk factors identified can be addressed and used in any healthcare campus or clinic.

1.8. Summary

This chapter has established the parameters of this research on covert violence in nursing in Western Australia and the reasons for the study. Chapter two discusses both historical and current research literature on covert violence.

2. LITERATURE REVIEW

2.1. Introduction

Since the 1970s community violence as portrayed in the media seems to be increasing on a daily basis. In spite of this it is often glorified and encouraged in films such as '*Silence of the Lambs'* and the '*Dirty Harry'* series, in books like 'The Shining' and even the 'James Bond' books, music such as Nick Cave's album *The Murder Ballads*, and video games such as '*Grand Theft Auto*' series. There have been some contradictory results amongst researchers regarding the effect of media violence on the community. Some, like Ybarra and Diener-West, et al., (2008) believe that there are linkages between media violence and seriously violent behaviour by youth. Others such as Ferguson and San Miguel et al.,(2009) attribute the rise of violence, not only to exposure to television, music and video games but also to the combined effects of peer pressure, family conflict, neighbourhood stress, and depression. Nevertheless, the fact is that violence is a problem, and all people regardless of age, gender and ability, have been affected by violence, some of them to the extent of injury and even death.

This chapter looks at various forms of covert violence that are encountered by nurses and highlights some of the international studies on covert violence in nursing. It also briefly examines covert violence in other workplaces in order to give a wider perspective of the phenomenon and to acknowledge that it is endemic in other workplaces as well as that of nursing.

2.2. Method Description for Literature Review

A review of published and unpublished literature relating to research methods and workplace violence and bullying in nursing and other

occupations was conducted using Google Scholar and Dogpile advanced search. The literature was limited to the English language and included published literature up to and including November 2011.

The keywords 'Workplace violence', 'bullying', 'horizontal violence', 'violence in nursing' and 'workplace stress' were typed into the search engines Google Advanced Scholar and Dogpile Advanced Search to access articles from international nursing and educational journals, occupational safety bulletins, conferences and unpublished theses. 21,800 publications were obtained. Publications were then limited to those published from 1969 to November 2011. One hundred and thirty two (132) journal articles were reviewed and relevant information obtained. Information from Occupational and Safety journals, legislation and codes of practice were also accessed and relevant research results used. Twenty one (21) online articles were retrieved for use as were 5 international conference reports. Information from 8 Masters' theses was also included in the research literature review.

The Edith Cowan University library collection of books and journals was searched for information on workplace violence and bullying. From this, information from 47 books have been cited. Western Australian newspapers were also searched and information from 14 news stories has been included.

In total, 287 publications including 25 laws and 3 Codes of Practice are cited in this research report.

2.3. Violence in the workplace

Violence in the workplace can be a major problem for both staff and the organisation concerned. It can impact on the organisation through a disproportionate turnover in staff, excessive absenteeism, work disruptions, decreased productivity, workers' compensation and

disability claims, discrimination complaints, employee sabotage, and a damaged reputation for the company or employer. Staff may suffer a decline in morale, go-slow or other sabotage activities, decreased job satisfaction and lost time through stress or unwillingness to attend the workplace. An Australian study of 2,487 nurses in 21 hospitals by Roche, Diers and Catling-Paull (2009) equated verbal abuse and emotional stress with ward instability, poor patient care, and staff restlessness. An English study by Lewis, Giga and Hoel in 2007 collated the Health and Safety Executive statistics for the year and concluded that work related stress in the United Kingdom cost the community over 4.55 billion pounds and workplace bullying cost 682.5 million pounds. Over 33.5 million work days were lost, over 200,000 employees left their employment and over 100 million productivity days were lost. There was a 1.5% decrease in overall worker production resulting in a Gross Domestic Production loss of 17.65 billion pounds.

An American study of 249 Emergency Department nurses by Johnson (2009) estimated that each nurse lost due to the effects of workplace violence could cost hospitals and health centres up to two-times a nurse's annual salary. Other research by Johnson, Phanhtharath and Jackson (2009) has equated this to between US$30,000 and US$100,000 per year. However much violence in the workplace is covert, therefore under recognised, understated, under reported and under treated.

2.3.1. *Forms of violence in the workplace*

Most people would think of violence as an act of force aimed at hurting another person or object. It is, in fact, far more than such overt activities.

Lutgen-Sandvik (2007, p27) defines workplace violence as 'a pattern of persistent, malicious, insulting or exclusionary intentional or non-intentional behaviours that a target perceives as intentional efforts to

harm, control, or drive a co-worker from the workplace.'   It may include:

- Physical – hitting, slapping, choking, pushing, using a weapon, restraining or kidnapping;

- Psychological – name-calling, harassment, creating a fearful atmosphere, threatening, bullying, the receiving of unsolicited telephone calls, emails or letters, being undervalues (e.g. being treated like a student), direct verbal statements, humiliation, given too much responsibility with little backup or experience, blocking learning opportunities, lack of supervision, threat of repercussion for speaking out, teasing, innuendo;

- Financial – withholding money or theft, extortion, failure to pay correct wages;

- Sexual – forcing someone to perform sexual acts against their will, rape, unsolicited comments about a person's sexuality, lewd posters, calendars or postcards that are displayed openly, or unwanted conduct of a sexual nature, or conduct based on sex, affecting the dignity of women and men at work (Rubenstein, 1988).   Other examples of this may include gender harassment, seductive behaviour, sexual bribery, sexual coercion, sexist comments and jokes (Till, 1980);

- Social – preventing someone from seeing friends or family, having someone followed or monitored;

- Neglect – failing to take care of, or clothe and feed children or adults;

- Client aggression – demanding better service in a derogatory way, blaming the employee for the faults of the business, rude, foul and abusive language.

A 2005 study of workplaces in Australia (Brokensha, 2006) reported that 43% of the 1200 employees surveyed had experienced some form of workplace violence, often in the form of bullying from their current boss. For example 52% of Government workers cited constant criticism and subversive behaviour from their bosses. A similar study (Taylor, 2009) cites further evidence that the Australian workforce concerns have not changed. It is reported that 50% of those surveyed had witnessed bullying behaviour and 25% had been victims of workplace bullying. Results also showed that less than 50% of workers were satisfied with their employers' actions on bullies. It would seem that bullying occurred at all levels of employment, reportedly up to 56% from senior management and 25% from fellow workmates and colleagues. An American study (Fisher-Blando, 2008) cites 75% of the 218 (i.e.163) research participants reported being mistreated or witnesses to workplace violence from co-workers or bosses, and 27%, (i.e. 59) had been victims of workplace violence in the previous year.

This concept of workplace violence is extensive, but, according to Einarsen et al., (1994) emerges when one or several individuals persistently over a period of time perceive themselves to be on the receiving end of negative actions from one or several persons, in a situation where the one at the receiving end has difficulties in defending him/herself against these actions.

2.3.2. *Costs of workplace violence to the organisation*

Workplace violence is a very expensive phenomenon. Penn, (2006), p. 46) quotes Western Australian government figures of 600 workers' compensation claims per annum related to workplace bullying and violence. '…this figure represents only the number of employees who have claimed workers' compensation; it is likely that many more incidents occur without being reported, and is 30% higher than last year.' In a UK survey, 17,000 employees were interviewed at

random from the Bristol Electoral Roll and were found to be suffering from workplace stress. From this, Smith interpolated that there could be up to 5 million British workers affected by occupational stress (Smith 2000), and an Australian study that same year cited that stress was the single most important occupational health and safety issue in the country (Australian Council of Trades Union (ACTU), (2000). A study conducted through Trinity College, Dublin in 2006 (Sheehan and McCarthy) estimated that in Ireland, internal workplace and bullying cost employers $16,977 per case. No doubt similar costs would be applicable for other countries, but regardless of the actual monies involved, covert violence in the workplace is expensive on finances, staff and organisations' reputations.

A Finnish study (Kivimaki, et al., 2000) estimated that of 5,000 hospital staff who had been bullied had over 25% more sickness absence than those who had not been bullied. This is obviously an underestimation of the problem. A study of nurses by Johnson and Rea, (2009) highlighted the issue of underreporting of violence in nursing. They concluded that nurses failed to report incidences of violence because it was considered too time-consuming, and there was a belief that violence is just part of the nursing job. There was also a lack of managerial support in that violent episodes were often downplayed or attributed to the victim rather than the perpetrator. There was also a belief that reporting such incidences would make little difference to the job itself, but the financial cost to the employer is immense. Premature retirements mean that lump sum payouts are required for each retiree, and there are the recruitment costs such as advertising, training and development of prospective employees.

2.4. Causes of workplace violence

The literature would testify that there are four elements that contribute to episodes of violence in general. They include (1) biological, (2) psychological and (3) social factors, each

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individually and collectively responsible for aggressive outbursts and physical violence, and (4) the necessity of businesses to operate smoothly, financially and structurally.

Fromm (1997) cites Freud as believing that there are two life 'drives' in each person. The first, 'eros' is the life drive of sexuality and creativity. The second is 'Thanatos'; a death drive expressed by aggression. Freud concluded that people who are overwhelmed by 'Thanatos' tend to become destructive when frustrated.

Lorenz (1966) agrees basically with this – that aggression is an inborn reaction which occurs when the 'right triggers' are exposed. Wilson and Kneisl (1992) also agree with these sentiments, suggesting, therefore, that people who display aggressive behaviour are not truly responsible for their actions – they are just victims of their own instinctive drives. Drugs, they write, do not cause violence, but a drunk or drug-influenced person – who is already susceptible to aggressive outbursts due to innate biological factors – is more likely to act out this aggression because the alcohol and/or drugs compromise their natural inhibitions.

There may be some truth to this, according to recent Canadian research (Young, 2009). Doctors from the Montreal Douglas Mental Health University Institute believe they have found a gene (NR3C1) which reacts to stress hormones dampening down the stress influence. This hormone is believed to be secreted between mother and child in utero and is linked to the mother's own psychological health. They found that when a child is abused or neglected, the gene is less likely to be activated at times of stress, resulting in depression and violence. Professor Young concluded that being raised in a stable and safe environment as a child helps us deal with stress in adulthood.

The psychological factors which relate to violence revolve around the need for personal gratification, a need to socialize, and a perceived loss of control leading to reduced self-esteem. Berkowitz and

Lepage (in Shaffer, 1997) concluded that aggression occurs when an individual is prevented from reaching a goal. The more important this goal is perceived to be, the greater the risk of violent behaviour which can be triggered by some external stimulus, for example the situation where a patient feels anxious and concerned about his admission to hospital or his test results. Because he may feel 'out of control' of the situation, he lashes out at staff in an effort to gain back his self-esteem and subsequent 'control' (p.12).

Social factors are deemed to also be responsible for the expression of aggression. Bandera, in Shaffer (1979) found that children who observed violent or aggressive behaviour were more likely to be similarly aggressive, particularly if the rewards (e.g. dominance) are seen as an advantage. Madden (1985) suggests that an individual is influenced by the mores of the social environment they inhabit. If a person has been victimised and has a history of deprivation or limited personal networks, then they are more likely to see violence as a means to communicate their needs.

Paik and Comstock (in Plotnik,1996) contest that watching violent television programmes and movies also has an effect on those who watch, citing that there is a significant correlation between aggressive behaviour in children and the amount and type of violence they encounter through the visual media.

A study of more than 500,000 Australian children by the White Ribbon Foundation (as reported by Pownall, 2008) identified that at least one in four had witnessed violence against their mother and more than half of the children had seen her subjected to emotional or verbal abuse. One in seven girls between 12 and 20 had been sexually assaulted or been forced to have unwanted sex. It also found that a third of the boys surveyed thought that it was acceptable to use physical violence against women and one in seven said it was acceptable to force a girl into having sex.

It was reported that in Western Australia 21% of young people said they had 'witnessed domestic violence against their mother, such as threatening her, throwing things at her, hitting her and using a knife or gun against her….almost one third said they had seen their father or stepfather humiliate her or put her down.' (Pownall, 2008, p.13).

Madden (1985) also suggests that violence in language can also be a harbinger to covert violence. He cites the use of the 'F word', now evolving into everyday acceptance as being a case in point. To previous generations the word was deemed as offensive and inappropriate in most social gatherings, but, with the rise of violence and violent speech in the various forms of media, it has become a generic word that young people learn amazingly early. Older people are finding the word offensive but younger folk are using it with no such qualms. This seems to incite violence between groups of people who would normally not become antagonistically involved.

Whether one accepts any or all of these theories of why violence occurs in society, there is no doubt that such violence is evident. An American study by the American Psychological Association (Tunajek, 2007), concludes that one in five American citizens have an anger management problem. There is no reason not to assume that Australian figures may be very similar.

Moore and Comer, (2005) looks specifically at workplace violence and links it to the fact that:

> ...within government and the private sector people are under enormous pressure to do more with less, to perform at higher levels without appropriate training and to meet unrealistic goals and deadlines…middle and senior managers are…under pressure from government, boards of directors and/or shareholders to create unreasonable expectations of their staff. In turn, employees 'implode' under the pressure, bullying others below them in an attempt to ensure that their own performance is not seen as wanting. Performance management is used as a veiled or overt threat to gain compliance (p.48).

The changing trends on the workplace can affect levels of violence within. There is increased commercial competition, even within public services such as nursing, the police force and government

offices. With this go tendering processes, restructuring and even organisational downsizing with the aim of cutting costs in order to win a tender (Cooper & Jackson, 1997) and a resultant increased risk taking (Quinlan 1999). There is also a growing propensity to offer part-time work or subcontracting in order to fill vacancies, either on a long or short term basis. All of this may lead to increased stress to workers, which in turn can result in increased covert violence within the workplace.

Further, Lindy (2009) adds the suggestion that managers, themselves, help perpetuate the problem of workplace violence because of their lack of action against it. She asserts that all managers have either experienced or observed negative behaviour between staff, but have failed to act because they felt there was an ethical dilemma about treating each member of staff equally and fairly, and they, themselves, felt unsupported by their seniors. With this, there is a perpetuation of covert violence within a nursing situation. Lack of support from other workers is also a topic of study reported by Paliadelis, and Cruickshank (2007). They concluded that nurses were not supportive of each other, and this included nurse managers who were reluctant to take sides during disputes.

 Covert violence in the workplace, then, is really a vast topic. There are as many reasons for this as there are examples of covert violence. Certainly it can be attributed to industrial competition, limited workplaces available, stress within the organisation regarding rates of pay, hours of work, and opportunities for advancement. Likewise, in nursing there has been an increase in the reporting of episodes of covert violence.

2.5. Covert violence in nursing

> …nursing provides an ideal incubation for fostering interpersonal conflict…either amongst staff themselves or between staff and patients. (Layton-Bennett, 2007, p.8)

Like societal violence, workplace violence is increasing, particularly in relation to nursing. The Canadian Public Health Association (1994, p.2) estimated that up to 70% of all Canadian nurses has been abused –'kicked, hit, verbally abused or sexually harassed'. This phenomenon appears to be increasing worldwide. However, most nurses choose to ignore it rather than be labelled a 'wimp' or worse, a 'dissenter'. Reporting incidences, especially involving other nurses is seen as 'childish' or 'unprofessional', and so is considered a waste of time and effort. Therefore underreporting begets underreporting. The situation rolls on and, from an historical point of view, nothing changes for the better. Indeed, nursing, itself may hold the key to this state of affairs.

2.5.1. *Nursing as a culture*

The history of nursing is grounded in the concept that somehow nurses are inferior beings to those of the medical fraternity, bound by a rigid discipline/obedience system, perpetuated by nurses themselves, and by members of the public who are influenced by images from the printed and visual media.

'Modern' nursing was instituted in the eighteenth century by Elizabeth Fry and Florence Nightingale. Prior to this, nursing tasks were carried out mostly by men and women who were employed to perform the most menial of tasks. There was no training and certainly no avenue of advancement in this position. Elizabeth Fry established the first training school for nurses in Britain in the early 1880s. They were granted a uniform and a starting wage of 20 pounds a year rising to 23 pounds after three years' work.

It was, however, not a job in which many were interested. Charles Dickens in *Martin Chizzlewit* (n.d.) parodied a nurse and midwife in the guise of Sairey Gamp as 'fond of a tipple which she kept in the teapot.' (p.411). Stachey (1918) confirms this with her description, 'A nurse was…a course old woman, always ignorant, usually dirty, often

brutal, a Mrs Gamp in bunched-up soiled garments, tippling at the brandy bottle or indulging in worse irregularities' (p.134). However, Florence Nightingale brought some respect for nurses during the Crimean War. They were given lectures in applying dressings, general hygiene and basic anatomy, and were taught, above all, to observe. '…how to observe, what symptoms indicate improvement, what evidence of neglect…' (Nightingale, 1969, p.105). They were also fated to a life of strict discipline. 'They could be dismissed for having a 'determined manner', for not wearing a hat, for not acquiescing to a head nurse' (Reverby, 1987, p.121) for complaining about not having enough to eat (Kalisch & Kalisch, 1975), for questioning hospital rules or for questioning a doctor's orders, (Ashley, 1976) . The Nursing Record 1892, (Tellis, 2003, p.51) declared nurses to be 'the white slaves of hospitals – overworked, underpaid, often more than half-starved inside their walls, or sweated as private outside nurses to produce larger profits for the hospitals, and then, when their health was broken down under the strain, discharged – tossed aside like old worn-out things.'

A London matron of 1888, cited by Jolley and Brykczynska (1993, p.14) wrote that 'no lesson is harder for the new nurse than that of discipline – the subordination of her will unquestioningly to that of another…she must bend under a law which is by no means always a law of love; never ask 'why', and as seldom as possible 'how', be content to bear unmerited blame without murmuring, to be scolded for mistakes that were made in all good faith; she must not be surprised to find herself vehemently repressed if she ventures on the faintest suggestion, and generally, if she is at all forward or clever she will be 'put in her right place'….it is the spirit of self-sacrificing loyalty that leads to the highest and truest disciplines,,,that remains loyally silent over its own wrongs, and punctilious to a fault in the fulfilment of its duties.'

Nursing as we know it today is an offshoot from this military-based system, trained by senior nurses and doctors, and rooted in the strict obedience required and with deference to seniors that such an

institution demands. Student nurses were to do as they were told with few avenues for questioning. The researcher can remember – even in the early 1970s – having to flatten oneself against a wall when a doctor walked by and having to stand to attention with hands tightly clasped behind the back as 'Ward Sister' walked into the office. Nurses were socialised into being the unquestioning handmaidens of doctors and the uncomplaining slaves of senior nurses.

With the advent of university-based nursing education, a rift appeared in the early 1980s between hospital-based trainees and university-educated graduates. To the former it seemed that the latter were not as much interested in the hands-on care of patients and wanted to gravitate instead to more desk-bound management areas or else advanced to senior positions that, now given in recognition of study gained, were previously given to nurses in recognition of their years of service and the knowledge thus gained. Experienced nurses who were once promoted to senior positions now felt that they had been passed over in preference to less experienced staff, and research shows that this may be at the root of much staff-to-staff violence, an apparent result of frustration and powerlessness when seniority is recognised, not by years of service but by pieces of paper obtained at a university

This power struggle often resulted in deliberate lack of communication between staff where one nurse does not pass on relevant information to another or perhaps only releases bits of information leaving the less informed feeling vulnerable, inadequate and often at the mercy of medical and other nursing staff and their expectations. A subculture related to power needs to be recognised for what it is – a definite form of covert violence which hinders an individual's work, and also the smooth running of a department or a ward.

Glass, (1997, p.15) sums this up as: 'Whilst it is distressing to even reveal, it is still evident that nurses are affronted by streams of

stressful encounters from their peers. They are continually exposed to negativity, and their so called healing environment reeks of professional jealousy.'

Most hospitals now have grievance officers allocated to assist staff who are having problems with other staff but it seems that they are underused. There is a reluctance to actually approach them lest the aggrieved staff is seen as emotionally inadequate, or just has a personal beef with another staff member. Until nurses, themselves, recognise 'internal' covert violence, then it will continue *ad infinitum*. It is a concept that affects all staff and ultimately all patients.

A second consideration is the idea that nurses are at work to care for patients and if they (the nurses) get hurt or offended in the process then it is just too bad. Hesketh et al., (2003, p.1) states that:

> A health care culture that is resistant to the notion that health care providers are at risk…(and) a complacency that violence…is part of the job. Such acceptance and resistance allows violent episodes to continue. They warn that '…when verbal abuse, threats of assault and low level violence are tolerated…more serious forms of violence will follow. (p.312).

Again, any covert violence needs to be recognised and reported. It is no longer acceptable to ignore verbal violence from patients, visitors or staff. If staff are expected to treat patients with dignity and courtesy, then patients, visitors and all staff need to treat nurses with the same care and sensitivity.

Having discussed the background to covert violence in nursing, one needs to look specifically at why such violence continues. It can be divided into three areas – the 'general' causes, the types of clients encountered, and the types of infrastaff animosity and why this arises. Firstly, 'general' covert violence.

2.5.2. *Causes of covert violence in a nursing setting*

> …high risks of violence occurs in …jobs that require
> workers to handle money or valuables; carry drugs or have
> access to them; provide care and services to people who are
> distressed, fearful, ill or incarcerated; relate to people who have
> a great deal of anger, resentment and feelings of failure, or who
> have unreasonable expectations of what the organisation and
> the worker can provide; carry out inspection or enforcement
> procedures; or work alone. (Warshaw and Messite, 1996, p.4)

The main causes of violence in a workplace setting, and most
translate across to nursing include:

- alcohol and other substances used by staff, patients and
  other people encountered in a health setting;

- increased exposure to violence through media presentations
  and general domestic circumstances;

- lack of positive role models in society;

- peer pressure when it is considered acceptable to be violent
  and

- rude or critical of others in order to be accepted by others in
  a social group, and religious and cultural differences.

Family lifestyles may also influence the behaviour of people, such as
the taking of drugs and alcohol, habitual family violence and child
abuse as compared with others' expectations of good will, courtesy
and respect. Perhaps associated with this may be lack of basic
education which may result in fear, concern and misunderstanding of
procedures that may be about to happen to a client, and their results.
There may also be feelings of mistrust or confusion due to lack of
reading ability or knowledge of the local hospital or of the health care
system in general.

Workplaces, too, may be at the root of some violence. This may be,
for example, where a large city hospital, because of its size, may
inherently allow a client to feel 'anonymous' whereas in a country

town where most residents are known to each other, this may not be the case. Similarly, in a small community, the reputation of the client may count against the person due to a previous admission or even his reputation around town.

The business hours of hospitals can also be an issue. Those hospitals and clinics which have twenty four access are often more open to violence from people who have been out drinking and partying (sometimes resulting in injuries from traffic accidents and fights) than in units that maintain office-type hours. Evening and night hours are also times of lower energy for staff which may also result in increased episodes of violence from both clients and colleagues.

Staff numbers may also be aligned to hours of business. Evening and night shifts are usually times of limited staff, enabling clients and staff to harass or harm staff at a higher level than during times of full staffing or during the day when ancillary staff may be in attendance or at least visible around the worksite.

The reputation of the worksite may also be a problem for both clients and staff. Clients who are admitted to certain hospitals or clinics may have a pre-formed idea of how they will be treated, from information given through the media, or perhaps from other clients or family members who have, themselves, been admitted to the facility and have not been satisfied with their care or the outcome of their admissions. Similarly, reputations of workplaces are carried from one staff member to another which may result in prospective staff not wishing to work at the facility or in specific wards or units.

From a management point-of-view, a Victorian (Australia) study of 24 managers in both private and public settings reported that they, too, had been victims of upwards bullying. They aligned this trend to changes within the organisations over which they felt they had no control (such as staffing, economics and career structure) (Branch, et al 2007).

2.5.3. *Client characteristics*

The type of clients and their responses to the health system is of importance, not only to the day-to-day running of a nursing unit, but also for future planning. Clients may have any or all of the following concerns - mental instability, fear and stress of the situation or expectations of the health service, influence of alcohol and other substances, irritation of waiting times or rules of the service which may or may not make sense at that time to that client, uncomfortable physical conditions of the service, feelings of loss of control as far as their health is concerned, feelings of prejudice or perceived prejudice against them by staff or the health system in general, and their previous medical history and experience as well as their family's medical history and experience. Any of these alone may trigger a person to agitation and violence, and if there are compounding characteristics, then the situation may become volatile and out of control.

2.5.4. *Causes of intra-staff violence*

The first cause is the staff members themselves. Field (1996) outlines several types of bullies. They may be in a position of power or domination or in a job where there is little or no scope for creativity or some who are professionally inadequate, incompetent or antisocial yet crave respect or power and so tend to point to others in wrong doing in order to take the interest off their own inadequacies. There may also be the attention seeker who wants to control or manipulate situations in order that they become the centre of attention. There are others who are task-orientated, control freaks with zero people skills who have sycophantic 'favourites' who allow them to become serial bullies. The targets of bullies are disempowered such that they become dependent on the bully or their advocates to allow them to get through their work day with as little stress as possible.

There may be staff in management roles who are poor people managers and some who actually may appear to condone or accept covert violence to other staff by either dismissing the issue considering it to be a personality clash, taking no stand against it, or perhaps threatening the 'complainant' with job demotion or limitations, or accusing him or her of being weak, oversensitive, a non-team player or a troublemaker (Wang, 2008).

The workplace may, in itself, be a cause of stress to staff. A hostile, unsafe and unhealthy workplace will contribute to staff dissatisfaction and frustration.   There may also be issues of environmental limitations such as space in which to nurse clients, to store equipment and in which to sit for 'timeout' during tea and lunch breaks. Constant noise from both inside and outside the workplace and poor lighting may also contribute to personal discomfort and increased headaches, and mental and physical fatigue (Lowe, 2011)..

Increased work demands may be the result of poor staffing levels, inadequate staffing, continual changes in staff, fatigue and increased time off. A competitive environment may also be the result of increased work demands, albeit psychological, but with the same attrition rates – 'the trouble is we're not talking about an environment which is a bit competitive, we're talking about an environment which is cut throat.' (Allen and Castleman, 1995, p. 26).

Given, then, a society in which violence is accepted as part of an everyday phenomenon, patients/clients who are anxious about the procedures relating to, and prognosis of their illnesses, and a set of staff who are discontent with their workplace, overworked and apparently 'unprotected' by management, this situation must by logic result in an unsafe, volatile environment in which both staff and patients are at risk. The cost of such a situation is expensive to both society in general and to the workplace in particular. These costs can be divided into society costs, staff costs and organisational costs.

2.6. Costs of covert violence

2.6.1. *Societal costs*

These include stress and trauma to clients, staff and families as well as interpersonal conflict and an increase in Medicare and disability claims. A decreased availability of appropriately trained staff may result in a loss of continuity of care. Workcover W.A. (2010) reported that mental stress accounted for 2.5% of all lost time injuries in the financial year 2008/09, the average length of time for which people who make mental health stress claims are absent from work was 134 *days.* This was from all worksites, not just nursing.

2.6.2. *Staff costs*

These may include general anxiety, sleep disorders, low self esteem, low morale, apathy, feelings of disconnectedness, depression and intentional or unintentional work absences. They may experience minor health complaints, insomnia, general feelings of insecurity, all resulting in a lack of personal or professional initiative. Those who are targeted may also take those experiences home with them, causing strained relationships at home, unrealistic demands on partners and families, or perhaps becoming isolated, even from their families. All of these may result in premature retirement (Shimizutani, Odagiri and Ohya, 2008, Stone, Du & Gershon, 2007).

2.6.3. *Organisational costs*

Costs of violence to a medical or nursing facility are diverse. According to Martin (2008), they include poor employment performance, decreased job satisfaction with a resultant decrease in productivity due to absenteeism and staff turnover. This in turn will result in the loss of valued employees and the inability to recruit and maintain staff. There may also be an inhibition of innovation or

creativity, and problems with future placement of both perpetrator and target. The Productivity Commission (2010) adds that a further indirect cost is the employee negativity to the organisation's brand and image.

Covert violence can cause a threat to the delivery of safe, quality patient care, and violates the bullied person's rights to personal dignity, integrity and freedom from harm. It also saps the life from the team spirit, collaboration, co-operation, personal and group satisfaction (Vickers, 2009).

Despite the legal requirements of management to provide a pro-active management of workplace bullying, there may still be an increase in legal liability and legal costs associated with staff dissatisfaction and for costs of repairs to premises and equipment to ensure the safety of remaining staff, patients and other folk who use the services or premises, as well as the costs for the original investigations (Martin, 2008).

2.7. Reasons for underreporting

So, given all the negatives of covert violence, why does it continue to be underreported and/or ignored? The reasons are many and may include simply not identifying behaviour as offensive and violent or not understanding the harm covert violence can do to the victim. There may also be a reluctance of staff to report the episodes lest they be deemed a 'dobber' or perceived to be weak in that they brought it on themselves. The perpetrator is often in a more senior position and the subsequent complaint may be seen as simply 'jealousy', resulting in further on-floor repercussions (Wilkie, 1996).

There is an element of shame in having to report an incident. The idea that nurses are professionals and should be able to cope with aggression or verbal abuse remains alive and so a complaint is seen as 'beneath' a professional demeanour, with the reportee being seen

as inadequate and uncertain leaving her/him with feelings of anger, embarrassment, guilt, a certain amount of fear – lest the reported one should retaliate –and hurt that their professionalism should be called into account. Shame responses and a threat to the well-being of other nurses and patients is believed to be a reason for under reporting, and this ultimately results in further incivility amongst staff and just perpetuates the problem, yet, according to Felblinger (2008), many staff members may actually be unaware that they are or have been tolerating unacceptable behaviour amongst their colleagues. If the same person is reported as a perpetrator or a particular unit is deemed more dangerous than another (for example, in Emergency Departments) there is often a complacency or desensitivity of management and other staff. Corney (2008) extends this shame theory to include a victim's family where the victim feels so inadequate and shameful that they fail to seek support from family members and other workers.

At a time of economic recession, there is also a reluctance of agency or casual staff to report incidences of covert violence fearing that they will further victimised, this time by the facility itself, in refusing to reemploy them.   Again, a misunderstanding of staff rights and responsibilities may limit the reporting of incidences that may result in a Workers' Compensation claim which may affect current and future employment possibilities (Wilkie, 1996).

For all these reasons, staff are often talked out of reporting incidences of violence, or simply decide that in their best interests no such information needs to be broadcast.

There is no doubt, then, that the management style and expectations of Nursing itself may be at the root of problem of covert violence. It is a military-based profession which has undergone major changes to the recruitment and study processes, in themselves causing discontent and jealousy amongst nurses. Also there is a societal acceptance of violence that spills over into many workplaces, including the health system. These two factors combine to make

nursing one of the most dangerous occupations in terms of the occurrence of covert violence. Incidences of covert violence are not only a problem for Australian nurses, covert violence is an international nursing problem.

2.8. International literature review

2.8.1. *Introduction*

Historically literature on covert violence in nursing came from The United States of America (Roberts, 1983). This chapter outlines what has been studied in different countries using registered nurses as participants and a broad definition of covert violence as the topic of interest.

2.8.2. *Australia and New Zealand*

The Workplace Bullying Project (nd) instituted in South Australia interviewed nurses from a wide range of health care settings. Over one hundred nurses responded. From the data collected, it was concluded that bullying was neither discussed nor adequately dealt with, thereby increasing stress levels in nurses even further.

An article by Leap (1997) cited another study by Hastie (1995) conducted in South Australia amongst midwifery staff following the suicide of a colleague. Many struggled to find a 'position' in an area where senior midwives ran units in which there was 'hostility and lack of support for junior midwives' (p.7). Leap relates this situation to 'social, political and economic inequalities linked to gender, subservient divisions of labour, medical and managerial domination, and lack of autonomy' (p.689).

Another study cited by Fisher et al., (1995) surveyed 237 nurses in remote areas, with over 41% response. The issues the nurses raised were:

a. there was no immediate support from medical or other health personnel;

b. exhaustion from being 'on call' for emergencies and accidents;

c. inadequate resources and accommodation;

d. no opportunity to share the responsibility of care with other staff;

e. fear of retaliation if violent patients were reported to police;

f. regional health authorities are often unaware of the demands placed on employees – and these employees believed that the authorities appeared not to care about the situation.

The study showed that in the previous 12 months, 82.1% of staff, (i.e. 194) had suffered verbal abuse and threats, 46.7%, (i.e. 110) had suffered property damage, nearly 32%, (i.e. 76) had been victims of sexual harassment, 17%, (i.e. 40) had received telephone threats and over 8% had been stalked by either a patient or a patient's relatives. The perpetrators were either a patient or a patient's relative, most incidences occurred at night (when staffing was limited), and they believed that drugs and alcohol were contributing factors to the situations.

In Fisher et al.'s (1995) research study, 32.8% (i.e. 78) nurses stated that their experiences when reporting the violent episodes to their employers (such as disbelief, blaming the nurse and the suggestion that perhaps they should work elsewhere) had made them reticent about reporting future incidences.

A further Australian study comes from the Queensland Nurses Union (1998). From responses they obtained from nearly 200 nurses they conclude that workplace bullying is on the increase, goes largely unreported and results in 'forced resignation, ill health, exclusion from productive duties and low morale' (p.1).

Farrell (1997) conducted a survey amongst nursing staff in all clinical settings in Tasmania concluded that most nurses were verbally abused or were victims of other forms of covert violence from their colleagues. Senior staff and managers offered little support and certainly no direct action. The nurses, themselves, put this situation down to a 'breakdown in relationship rules' such as lack of respect for each other and a violation of privacy (p.507).

Hockley (2000) conducted a survey amongst nurses, specifically on the topic of stalking by females. The Oxford Dictionary (Fowler and Fowler, 1997, p.1513) defines 'stalking' as being '…to follow, dog, haunt, shadow, trail, track (down), hunt (down), prey on, pursue, hound, chase…' Hockley found that nurses reported stalking from both patients and staff at work and in the community to the extent that they became 'paranoid, depressed ….suicidal'. When the victims reported their concerns they were told either that the staff member/s in question was only checking on them for an upcoming appraisal or were just 'supervising' them (p.9). The researcher reports that, only when faced with legal action, did previous patients ceased their surveillance of the staff member.

A taskforce under the direction of the University of New South Wales studied the health system in 2001 concluded, then, that covert violence was rife and may be a result of nurses seeing themselves as powerless to improve their conditions, and acting out their frustrations (Mayhew and Chappell, 2001). They found that the targets of bullying were usually more attractive, confident, successful, qualified or popular than are the perpetrators. The list of reported abuse included:

- verbal abuse or sexually explicit language

- spreading rumours

- displaying degrading materials

- unprovoked outbursts of anger

- removal of responsibility and replacement with trivial tasks

- taking credit for work done by others

- withholding information and resources

- criticism in front of others

- poor shift rostering

- blocking promotional opportunities

- work overload

- threats of job security

- constant watching

- sabotage of property and equipment

Such actions, the study found, often resulted in unresolved relationships breakdown resulting in many nurses simply leaving the organisation and the profession in general.

Another study by a taskforce established through the University of New South Wales in 2001, led by Mayhew and Chappell, confirmed that female staff in the state were subject to high levels of verbal and sexual abuse. On the whole, such episodes were not reported unless it was considered repeated or escalating. This violence was recognised as being perpetrated by both patients and staff.

The clients who were most verbally violent were identified as mostly unemployed, 'marginal'. Often under the influence of drugs or alcohol, had been waiting for over twenty minutes, were often in (therefore) untreated pain, were often non-compliant with their medications, and many were not English speaking. Internal violence was experienced by staff who were from Nursing agencies, therefore were casual staff at the hospitals and clinics surveyed. It was also experienced when permanent members of staff felt that they were in

some doubt as to their job security. The staff who were 'reported' as being abusers were often unaware of their effect on other staff members.

In 2004 Taylor and Barling surveyed twenty nurses concerning career fatigue and burnout amongst mental health staff. They cited the undervaluing of nurses by both patients and staffs, issues with management and general nurse-to-nurse conflict as being the most common reasons for reconsidering mental health nursing as a lasting profession.

A 2006 study in Tasmania by Farrell and Bobrowski revealed that, from the 2407 respondents to their questionnaire 63.5% of staff had suffered verbal abuse from patients and staff in the previous 12 months. This was accredited to illicit drug use and resistance to healthcare intervention by patients, and a frustration by staff that they could not provide adequate and appropriate level of care for their patients. Regardless of reasons, the participants identified that it (covert violence) further influenced their distress, resulting in reduced productivity, an increase in the potential to make errors and a lack of desire to stay in nursing.

In 2009 The West Australian newspaper cited a study of violence experienced by staff in Perth hospitals and labelled the situation as an epidemic of abuse and violence (Tillett). The study included issues such as pushing, hitting, kicking, biting and verbal abuse, concentrated solely on patient to staff violence. It was recognised that there were various solutions being instituted but each were 'long term. Something needs to be done now to address it.' The article quoted Australian Nursing Federation secretary, Mark Olsen as saying '…It's hard enough to find nurses as it stands. If they're increasingly being seen as a soft target for assault, then we'll see even less people take it up' (p.17).

A questionnaire, specifically regarding the issue of verbal abuse was sent to 62 female nurses in a private hospital in Victoria by Martin,

Gray and Adam in 2006. The results found that 37.14% reported moderately frequent verbal abuse, 1.43% very frequent verbal abuse, and 61.3% reported that either verbal abuse was infrequent or not regarded as being an issue in their workplace. Interestingly, on the whole, the nurses reported that verbal abuse was less acceptable in their everyday work experience than in an emergency situation, and more offensive and hurtful when perpetrated by a colleague rather than by a doctor or patient.

A 2006 survey by Hutchinson, Vickers, Jackson and Wilkes interviewed twenty six nurses about their experiences of workplace bullying. They concluded that often this situation arises because of planned, predatory group bullying acts, and that there was evidence of the concealment of bullying and protection and even promotion of the perpetrators.

By 2007, research by the Australian Institute of Criminology (Murphy, 2007) identified that 'the health industry is the most affected by violence, and the occupation of Registered Nurse is the second worst affected occupation in rank for violence' (p2). A system of zero tolerance is recommended with victims reporting violence episodes to police, '…even if assaulted by a medically or mentally unfit person' (p.2). In the same year Alspach's (2007) survey of 709 critical care nurses concluded that between 23% and 32% reported fair or poor quality of interaction with peers. They referred to 'powerful and elite' groups within their workplaces which control and exploit a less powerful group, resulting in an oppressive working environment and a build up of anger, frustration and tension – unresolvable issues that affect every part of their working life.

Martin, Gray and Adam (2007) conducted research involving 70 female registered nurses, on verbal abuse occurring in a private hospital. They defined such behaviour as including 'communication tactics such as humiliation, sarcasm, insults, labelling, and blaming in an attempt to discredit the victim' (p.42). In this study 37% cited that they have been victims of frequent verbal abuse and a further 1.43%

reported the problem was 'very frequent'. Overall their responses confirmed that nurses received verbal abuse from mainly male doctors, more often in a non-emergency situation, but they felt more aggrieved when the abuse came from fellow nurses. They suggested that influences such as gender, power (of both medicos and senior staff) social identity (being in an 'ingroup' or an 'outgroup' – a form of elitism) contributed to the problem that those nurses who were naturally assertive or had had assertiveness training coped better with the abuse, and often managed to have it stopped by confronting the aggressor directly. The respondents reported that, although given some assertiveness training, little else was done to prevent this form of covert violence from continuing. Management were not interested or tended to play down the issue.

Research by Lea and Cruickshank (2007) into the assimilation of newly registered nurses into hospitals in rural New South Wales found that there was issues of elitism and social 'mobbing' which caused stress and anger resulting in new staff moving or considering moving elsewhere if possible.

Elitism took the form of already-established friendships between staff members preventing new staff from infiltrating into the social side of ward work resulting in negative, hostile undercurrents and general unprofessional behaviour. To complain to management was deemed worthless as often senior staff were the perpetrators of covert abuse, and they, too, were friends with management. So these complaints were either overlooked or simply dismissed.

Another issue cited by Lea and Cruickshank (2007) was that of unfair workloads. In rural hospitals it is often the case that a ward is managed by one RN and one or more EN, regardless of the inexperience of the new RN and they are expected to cope. 'They don't see you as a new grad here. They see you as having RN next to your name, you can have the full patient load, don't talk to me unless you have a problem' (p.5).

Along with this was the expectation that the ward nurse would also, in some situations, be responsible for any incoming emergencies as well. No extra staff was available, unlike some city situations where agency staff could be called on. Many believed that this was beyond their level of competence, knowledge and experience. The findings of this research were that ward culture, the isolation of rural communities, staff shortages and the fact that in such a community, nurses often have to work, play and socialise with the same people, making a hostile or unaccepting workplace an even more difficult situation. If the new nurses transferred or moved to a rural area because of family commitments and work, then they are obliged to either accept such covert hostility or leave nursing. Rarely is there another hospital or clinic in which to work in the same town.

A study of twenty nurses in one specific operating theatre complex in Queensland by Gillespie, Wallis and Chaboyer (2008) found that social order, experience and knowledge was used by members of the 'team' both negatively and positively to effect whether nurses were determined enough to stay in the unit or leave. The amount of knowledge provided and social acceptance given by other staff members were meted out according to those staff members' acceptance of the new staff member themselves. This created a potentially hostile environment where knowledge and social interaction were power and this was wielded over all new staff. High turnover rates were evident and the researchers believe this contributed to ever increasing staff shortages in this particular specialty.

A Western Australian study of violence experienced at Royal Perth Hospital, a central city establishment found that violence and intimidation against staff had increased by 350% in the previous five years, with 240 incidences reported each month. The reasons given for these figures are patients' frustration at waiting too long for a bed, alcohol, and amphetamine use (Prior, 2008).

A New Zealand study of 551 Registered Nurses in their first year of nursing and across all clinical settings cited interpersonal conflict is a 'significant issue' in nursing (McKenna, et al., 2003, p.90). These included verbal abuse, intimidation, humiliation, criticism and exclusion. It resulted in absenteeism and a high number of nurses considering leaving the profession. Covert violence is reported in less than 50% of the time mostly for fear of retaliation. In those reported, only 12% 'of those who described a distressing incident received formal debriefing' and very few respondents had had access to any suitable training to minimise the violence and violent behaviour of workmates. McKenna's concern was that, if this data represented first year nurses, what figures would be available for more senior staff? 'Given the central focus of caring in the nursing profession, it is paradoxical that interpersonal conflict is a significant issue confronting the nursing profession.' This is not just a problem that Australian nurses experience, but a world-wide nursing problem that occurs in many other countries, including Canada.

2.8.3. *Canada*

In Canada, because there is no specific method of reporting covert violence, most collected data is in anecdotal form. Canadians Spring and Stern (1998) write solely on intra-staff or 'horizontal' violence. This can be described as behaviour which is perpetuated upon a colleague in order to frighten, intimidate or belittle. It can also be more subtle as in poor/unfair rostering, partnering with difficult staff, non-acceptance of roster requests or the giving of a task which is either beneath a nurse's qualifications or too difficult to achieve. The authors consider it to be 'too often unidentified and tolerated.' (p.1). Nurses have been socialised for generations into accepting this abuse. Spring and Stern do not address other forms of covert violence but admit that intrastaff violence robs nurses of their time, energy and devotion to their profession.

Horizontal or intra-staff violence is also discussed in the *Canadian Nursing Advisory Committee* (2002). Staff canvassed were nursing

assistants but the collected data is similar to that collected from registered nurses by Spring and Stern (1998). They align the covert violence to low staff/patient ratios, low pay, long working hours and peer dynamics and politics. The ramifications were 'anger, low self-esteem, stress and feelings of hopelessness and helplessness'(p.1).

Henderson (2003) studied workplace violence in Canada and the United Kingdom and the effect it had on the nurses' care for their patients. In a qualitative study she interviewed 49 Registered Nurses, 25 in Canada and 24 in the United Kingdom. The data was collected using questionnaires and taped interviews which addressed the factors within their working environment which had an impact on their work. She found that most nurses were subject to both verbal and physical abuse on a daily basis and threats of job loss, demotion and harassment from patients, their relatives and from other staff. This did not occur just in emergency and psychiatric settings, but throughout the entire health service setting, both in urban and rural areas. She cites Whitely et al., (1996, p12):

> 'The environment within the health care arena is fraught with violence and potential risk. Violence affecting nurses in the workplace continues to escalate.'

The Canadian Nursing Advisory Committee (2002) has stated that staff receive little support from within the setting or organization when abuse or violence is encountered. 'The abuse continues at virtually the same rate as reported … almost a decade ago.'

Hesketh, et al.,(2003) conducted several studies into workplace violence over two provinces in Canada involving 8,780 nurses. This was done by offering face-to-face interviews and also opportunity to write anecdotes about incidences and how they were dealt with, by both nurses and management. They concluded that nurses were experiencing many incidences of violence including abuse committed by hospital co-workers, particularly emotional abuse and sexual harassment. Thirty eight percent reported emotional abuse, 19% physical received physical threats, and 7.6% were victims of verbal

abuse. A further 35.4% reported overt violence episodes – not covered in this research. Their results show, however, that most incidences of covert violence (up to 70%) were not reported for fear of 'victimisation' by their peers or more senior staff.

The Registered Nurses Association of Nova Scotia (RNANS) (1998) reported that covert violence in nursing was rampant and has released a Resource Guide for nurses. Most of their data has been collected using a write-in web site where nurses can detail their experiences of covert violence. The association lists triggers which may lead to workplace violence such as environmental factors, staffing ratios, staff characteristics and organisational policies and politics. It highlights some of the issues, both internal and external, which contribute to violence in the workplace. This study has cross checked its findings against these reported triggers by the RNANS (1998) to assess their consistency across a broad nursing base.

A 2006 online survey of Registered Nurses by Ulrich and Lavendero et al resulted in over 4000 respondents from Critical Care nurses. They recorded that 64.6% were subject to verbal abuse from both staff and patients, 1 in 5 had been sexually harassed in the previous year, 1 in 4 believed they were victims of discrimination, and 18.4% did not know there was a policy in place to report such episodes.

Results of data from Canadian research shows that the causes of covert violence in nursing are similar to those in Australia. They include triggers from workplace issues such as staffing ratios, environmental factors, client and staff characteristics, and lack of policy compliance from a management level.

Another country in which nurses report experiencing covert violence is the United States of America.

2.8.4. *United States of America (U.S.A.)*

A study by Furlow and Bushby (1998) in the United States of America concentrated on nurses working in an operating room (OR). They found a situation they referred to as a balance between 'power and powerlessness' and align covert violence towards nurses as a result of the stereotypical views of men and women. Women (nurses) are seen as gentle, compliant, passive and powerless (especially married women) whereas men (doctors) are seen as dominant, self-reliant and powerful. Dominance was also evident in the fact that nurses' actions were being continuously scrutinised by both doctors and management, and the tradition of OR rituals such as 'gowning the surgeon' just perpetuates the problems. They suggest that, in order to assert themselves, nurses resort to 'subtle, passive-aggressive behaviours' such as padding time cards and extending lunch breaks (p.3).

Lybecker (1998) in an American study suggests that under-reporting of covert violence is for 'fear of reprisals, the belief that reports will not be taken seriously, and the effort itself if not worthwhile '. She quotes American Occupational Safety and Health figures to show that nurses and other health care workers are assaulted in the workplace more often than other groups of workers, and yet less than 20 percent of all incidences are recorded. This research study has attempted to question why individuals do not report covert violence in their workplace.

Another American study was tabled at the International Labour Organisation's (ILO) seminar on 'Violence on the Job – Global Problem' at Geneva in July 1998. Three specific types of covert violence were discussed – bullying, ganging-up or mobbing, and being forced to work alone. They resulted in nurses being unduly stressed, depressed, tired and nervous. Bullied nurses were unable to maintain interpersonal relationships and lost their personal and corporate image and self-respect.

Skillings (1992) found in her study that nursing staff were oppressed and this oppression was multidimensional and socially constructed. Management and peers refused to support other staff and this resulted in a form of power struggle where younger staff were not socialised or educated into their work leaving them with few actual learning opportunities. New or younger staff members were somewhat ostracised when it came to making decisions concerning the running of their wards or units, yet apparently expected to 'know' about, and how to deal with the changes. When difficulties arose through lack of 'knowledge' these nurses were further challenged and harassed about not being able to 'keep up with things'. Skillings reported that this resulted in a continuous cycle of bullying leading to further oppression A more recent study from the Massachusetts Nurses Association (2005) found that, despite all that has been written about covert violence, over one third (1/3) of the 172 nurses surveyed had been abused in the workplace. Following this finding the message was that '…the value of human life is inestimable and those who serve others, such as nurses, must be protected from attack and shielded from abuse' (p3).

Kulwicki (2000) concentrated on patient/nurse covert violence in the United States of America (U.S.A.). Most of the incidences reported in her study occurred between nurses and Arab Americans. She summed up the problems in this 'exclusive' study, certainly stating that such incidences were unacceptable, but associating the complexity of health care with culture diversities and communication gaps. This issue, she believes, need to be addressed urgently in the U. S. A. and anywhere else the violence occurs.

An article by Anna Gilmore-Hall (2001, p.4) reported that 'working in a health care facility is considered to be the third most dangerous job in the United States.' She believed the problem to be increasing due to staffing shortages, the wider use of law enforcement in hospitals, the releasing of mentally ill patients into general hospitals and the community and the ease with which people can obtain money, drugs and guns. A similar study in the same year by Vance (2001) also

concluded that 'working in a health care facility was the third most dangerous job in the U.S.' A 2003 study into violence in hospitals in the USA, by Sofield and Salmon concluded that, of the 1000 nurses surveyed, up to 97% of all nurses experienced verbal violence in their workplace. So entrenched is this problem that Aiken, et al (2001) cited from their studies that up to 16% of staff left/retired specifically because of issues directly related to verbal abuse, etc.

A study by Martha Griffen (2004) involved information gathered from twenty six newly licensed nurses in Boston. She identified the 10 most frequent forms of lateral violence as nonverbal (e.g. raising eyebrows), verbal affront, undermining activities, withholding information, sabotage (deliberately setting up a negative situation), infighting, scape-goating, backstabbing (complaining to peers and not confronting the colleague involved), failure to respect another's privacy and broken confidences. Staff were trained in recognising such violence and the confrontation of the person involved to resolve the situation. Griffin concludes that the retention rate of the study group was positively affected when these strategies were used to resolve situations.

A study of 20 registered nurses in the same year through the New York State Nurses' Association found that all had been subjected to verbal abuse within the previous year, and all had been a witness to such events, although none had reported the incidences as either victims of or witness lest they not be believed, or were threatened with losing their employment positions or jobs. (Vance, 2004).

Purchase (2004) completed a survey of 229 registered nurses through the New York State Nurses' Association. 46.9% of respondents reported being victims of verbal abuse and over 17% reported receiving offensive sexual comments or innuendos. Male nurses from this survey reported covert violence was a sexist activity because women were seen as weaker and therefore were more frequent targets for such episodes.

Lewis et al., (2005) in her research into intra-staff bullying found that it was a learned behaviour rather than a psychological incident from perpetrators. It was learned from student days and, because there is rarely any official action taken, it continues unchecked and underreported.

The Hawaii Nurses' Association (2007, p.3) regards staff bullying as a means of 'oppression and power', often associated with structure and 'systems' issues that result in pent-up tensions and severe psychological damage. This can include loss of emotional control, lack of emotional control, and apathy. Eventually the situation results in the victim being unable to ignore the situation, depression and long-term impaired personal relationships. They found that few nurses report abuse because they '..do not feel supported by administrators when incidents arise.' Its message is to report all incidences, seek witnesses, and to be cautious in dealing with patients who are known to have a history of violence.

A survey by Zuzelo (2007) of 100 nurses found that they were victims of 'moral stress'. This arose because of poor and therefore unsafe staffing levels and situations where the nurses disagreed with the treatment plans. This situation presented moral and ethical dilemmas affecting patient care and nurse support which they attempted to gain (unsuccessfully) from other staff members, management and from chaplaincy services.

Simons (2008) investigated forms of disrespect in a Neonatal Intensive Care Unit (NICU) involving 40 nurses. She found there was a great deal of peer-to-peer abuse, sufficient to create a negative attitude to both the unit and to nursing as a whole. Because of it job dissatisfaction and staff turnover were rife, impacting on patient care and safety, and causing a lack of supportive teamwork. The role of nursing leaders is called into account to maintain ongoing civility and a caring culture within the confines of such enclosed and often 'isolated' units.

The same researcher studied bullying between Massachusetts Registered Nurses and the relationship to their ultimately leaving a particular organisation. (Simon, 2008). Of the 511 randomly selected nurses, 31% reported being bullied and this had a significant bearing on their choice to leave their places of work. Simons concludes that the effects of bullying are not taken seriously enough, resulting in high rates of nurse turnover.

These studies show similar causes of covert violence in nursing in Australia, Canada and the United States of America which include bullying from both patients and colleagues and lack of managerial support. Horizontal violence is also highlighted in British studies.

2.8.5. *United Kingdom (U.K.)*

A study conducted by the Royal College of Nursing (UK) (1998) revealed that bullying persists because staff felt unable to report such behaviour for fear of job loss, demotion or victimization. This study was conducted using data collected from a phone-in session where nurses rang to complain about situations they found stressful in their workplace settings. Over 200 nurses rang in and their concerns were documented and assessed. Freshwater, (2000, p.482) concludes from her study of nurses in England that the hardest acts of aggression to deal with are 'the non-physical attacks, the hostile undercurrent that prevails'. She cites the experience of British nurses as being similar to an Australian nursing literature study from Tasmania by Farrell (1997, p.32) when he describes these forms of aggression as 'professional terrorism' and includes situations such as clique forming amongst staff, refusal of senior staff to debrief or even assist in violent/covert violent episodes and the seemingly intrinsic powerlessness of nurses to speak out and change the work situations for themselves.

A specific example of workplace bullying was reported in 2002 by the BBC. An Iraqi-born surgeon was struck off the General Medical

Council as 'he bullied and groped staff and was insensitive towards patients'(p.1). He was an accomplished surgeon and author, but made sexual advances to 10 staff members over a four year period. One anecdote from a senior ward nurse was that he 'slipped his hand into her knickers and asked: 'What are you doing tonight?' It is stated he said 'women are only here to pleasure men and that he would like to have four wives.'(p.2). (In the Arab nations it is normal to have four wives, and for men to divorce their wife as soon as they tire of her so they can get a new wife. The first wife is often the head wife and bullies the other wives). This behaviour continued for so long because, as a colleague stated, 'He is such an arrogant person. Nobody could stand up to him because he was so abrupt and rude.' (p.3).

An Irish study of eighty nurses in emergency departments by Ryan and Maguire (2006) cited that emergency unit nurses were more likely than other workers to be the victims of violence or aggression. Verbal abuse was the most reported type of violence (46%) from both patients and staff, and yet less than one third of staff had had any access to training in the management of aggression or even reported the incidents. In some cases, this education was available but workloads and expectations prevented staff from attending.

A research study of covert violence was made by Alexis, Vydelingum, and Robbins (2007) and involved 24 nurses from Asian, African and Caribbean backgrounds who had been recruited to the UK to work by the National Health System. Six specific themes arose including a feelings of devaluation and self-blame, lack of equal opportunity, apparent invisibility, discrimination and fear. White UK nurses tended to not trust them, leaving them feeling isolated and depressed. They believed that, although the nursing experiences gained whilst in the UK were helpful, their actual treatment was unacceptable. Rarely did anyone report any incidences of verbal and social abuse for fear that they may be seen as troublemakers or 'stirrers' and thereby limiting their future opportunities to work,

ultimately being forced to leave Britain and take their families with them.

Nursing studies in other countries are finding the same principles and types of violence in their hospitals and clinics. Most of this research is from European countries, with little found from Asia.

2.8.6. Other countries

Similar to the United Kingdom research, studies from Norway show the same types of violence in nursing organisations. Einarsen and Skogstad (1996) cited 54% of their large studied group of 7986 nurses experienced bullying by co-workers, often superiors and sometimes apparently designated as 'harmless' such as the violation of the personal space of colleagues. A second study in Norway cited in Einarsen and Skogstad, (1996) reported that of 58 psychiatric nurses canvassed, over 10% had been 'bullied, badgered, harassed, teased or excluded by colleagues over a 12 month period'.

A study in Turkey by Uzon (2003), collected data from 467 nurses working in various nursing situations in 3 different hospitals using a 23-item questionnaire, specifically on verbal abuse. The findings were that most nurses had been subjected to verbal abuse (86.7%) and that 92% reported that this regular verbal abuse lowered their morale and affected their job satisfaction, and therefore had a negative effect on their families and their patients.

A study sponsored by the International Labour Organisation and conducted by Susan Steinman looked at violence within the health sector in South Africa (2003). The study involved both qualitative and quantitative surveys in the Greater Johannesburg Metropolitan region deemed to be 'fairly representative' of urban South Africa. Two hundred registered nurses from all types of workplaces were surveyed using questionnaires and face-to-face interviews. Steinman identified the extremely high levels of workplace violence (61.9%) as

'shocking', higher in the public health service than the private sector, more prevalent in larger facilities than in smaller ones, often race and gender orientated and may reflect a lack of teamwork and a sense of loyalty amongst workers.

A 1997 study of nurses in Pretoria (Ngwezi), quoted that 61.6% of 'black' nurses surveyed reported poor interpersonal relationships with doctors and superiors, 56.6% reported a low 'team spirit' in their workplace, 36.6% reported unreasonable behaviour such as rudeness and favouritism from senior staff, and 36.6% reported being abused by angry, drunken and over-demanding patients.

A Swedish study by Arnetz, Arnetz and Petterson, (1996) surveyed 2600 registered nurses and found 29% of respondents had been victims of covert violence and 35% had been verbally threatened at their workplace.

A study was cited by Josefsson et al. in Sweden (2007) where 213 Registered nurses in both dementia specific and other elderly care facilities were canvassed re their perceptions of violence and threats in their units. The results showed that over 45% of all staff had been threatened by patients, relatives or staff, and at least 30% of each were witness to such violence to other staff. Very few staff were able to access any education on the topic and it was a major contributor to many nurses' decision to resign from, or be reassigned in the workplace.

A reported study of French literature on workplace violence in nursing by Tragno, Duveau and Tarquino (2007) cites in a study of 230 French nurses in which over 90% were victims of workplace violence or intimidation from either patients or colleagues. They confirm that this may be the case throughout all of Europe.

A 2003 questionnaire regarding verbal abuse from doctors was sent by Oweis and Mousa to 138 nurses in 5 hospitals in Jordan. The results were that all were victims of verbal abuse by medical staff. There was much judging and criticising, accusing and blaming (for

poor equipment, short staffing), and aggressive, abusive anger in general. Because of this, all respondents reported that they suffered shame, humiliation and frustration with their workplace and other staff.

The literature, then, confirms that covert violence in hospitals and clinics is endemic within the nursing profession. The causes are very similar. They include environmental factors of the nursing workplace, personal characteristics of both nurses and patients, unwillingness or perceived inability on behalf of the nurses to report incidences lest their position be jeopardised or they are made to feel foolish, even childish, in front of their patients and peers, and the lack of support given by managers when episodes of covert violence is reported. However, nursing is not the only profession or occupation that is affected by covert violence.

2.9. Covert violence in other workplaces

2.9.1. *Introduction*

Nursing is not the only occupation in which covert violence is a factor of staff discontent, distress and even early retirement. It is an international problem that involves workers of all employment strata, and all economic levels. To illustrate this, some mention is made of research conducted in other workplaces on the topic of covert violence. This literature review is not intended to be a finite list of occupations or problems, but to provide some insight into the problems of workers in other occupations who report episodes of covert violence in their workplaces.

2.9.2. *Education*

An Australian study in 2003 amongst tertiary campuses, involving 100 teachers, (McCarthy, Mayhew and Barker) reported that the

perpetrators of covert violence were mostly students (11%) with fellow teachers and administrators making up 6%. The element of violence was blamed in part to society's current acceptance of violence and also to the pressure of student numbers and financial bonus in graduating adequate numbers. One of the recommendations of the study was simply to fail students who were instrumental in creating or maintaining the culture of violence on campuses.

One hundred and seventy two North American teachers were surveyed by Blase, Blase and Fengning (2008) and they reported constant and ongoing harassment by principals. This, also, may reflect the pressure on principals to bring and maintain their schools up to modern expectations, often with poor financial backing and limited educational facilities. These impacted on teachers' work and their families, as well as personal issues such as lack of self-esteem, reluctance for further study, sleep disturbances, headaches and general health concerns. In spite of teachers understanding these issues, 77% (i.e. 132) of the surveyed participants stated that they would leave the profession.

Another North American study by Dobmeier and Moran (2008) involved 31 teachers of adult students at a New York State college. The online survey highlighted pupil inattention, rule breaking, behaviour that offended others, and written and verbal threats. The teachers recognised these disruptive behaviours as being a result of drug abuse, psychiatric disorders, Attention Deficit Hyperactivity Syndrome and of general learning disabilities of the adult students involved. They also acknowledged that some environmental factors such as poor lighting of classrooms and halls, inadequate educational facilities, poor economic states of some of the students and limited job expectation, even after graduation, may be to blame. Nevertheless, such behaviour left the teachers stressed, tired and, for some, looking for employment either at a different college or in a different profession altogether. Bloom (2008) states that Connecticut

anti-bullying statutes are not strong enough to be of value to teachers and to relieve them of their stress and discontent (p105).

A research paper by Tschabangu (2008) studied school violence in Zimbabwe, looking at violence from two different points of view – violence towards the students and violence directed at teachers. The researcher concluded that the situation, apparently rife across the country, was due to macro-politics of Zimbabwe itself and micro-politics of the education system.

This dichotomy between macro- and micro- politics is also evident in nursing. These issues have a major effect on the day-to-day workings of a hospital or health centre. The basic supplies of equipment and even teaching facilities are governed by the micro-politics and finances of the centre itself, and the hospital or health centre is in turn governed by the macro-politics of the local and national governments' financial stipulations and policies.

The eight secondary schools and one teacher training college surveyed by Tschabangu (2008) reported student beatings (300 students participated in the research) and manual labour that was given to the students for misbehaviour. The school system sought to produce bodies that were docile and capable in order to maintain discipline. Teachers, also, had to adhere to a strict code of conduct, often against their own beliefs and personal wishes. The researcher concluded that the whole school system was geared towards the establishment of authority, not of justice, and so this is breeding an atmosphere of mistrust and disrespect between students, between teachers and between students and teachers. For this study 65% of the teachers who responded to the survey (80 teachers, 30 trainee teachers and 7 lecturers) really wanted the opportunity to change the situation but felt inadequate to do so, resulting in frustration for their work, their own mental health, and their teaching future as well as the future of national education.

A 2005 study of three hundred and sixty five homosexual teachers in Ireland by Norman concluded that 93% reported that their school had an anti-bullying policy, yet 90% of these teachers said it did not relate to lesbian or gay bullying. The respondents felt that they were victims of verbal abuse, and most had had offensive language directed towards them such as 'queer' or 'lezzie'. The research showed that such covert violence was less evident in girls' single-sex schools than in boys' single-sex schools or co-educational schools.

A book by Skelton and Francis (2005) reported that in the United Kingdom, if any rumour of being gay was spread among the parents, life in school would be unbearable. This was for both male and female teachers alike. In order to 'live' with the threat of unwanted media coverage or loss of job security, teachers felt that they needed to keep a low profile and 'hold back, just keep acquaintances superficial' (p225), and to generally lie about their lives. There was implicit harassment from school principals with threats of dismissal, coded discussions, and increased monitoring and surveillance of gay teachers.

From these studies it is obvious that there are many similarities between covert violence issues in education and in nursing. They include the apparent acceptance of violence by society, financial pressures of both forms of institutions, harassment by senior staff members, disruptive behaviour by student and patient, and gender harassment.

 As well as in the educational profession covert violence has been documented as occurring in the medical profession.

2.9.3. *Medicine*

An Australian online study by Koritsas, Coles and Boyle (2008) of five hundred Local Medical Officers (General Practitioners), both male and female, has revealed that from 55% - 64% had

experienced episodes of covert violence from their patients in the preceding twelve months. They attributed this to increased substance abuse by their patients and the general societal attitude change towards professionals in particular and violence in general. This left the doctors with an overall feeling of vulnerability, and symptoms of stress which furthered feelings of lowered competency, increased opportunities for mistakes and decreased work performance. It also reflected the concept of 'instant service' with people unwilling to wait quietly for a reasonable time or order that patients with already-arranged appointments or those with more serious health problems could be seen first.

A research study by Kornstein, Norris and Woodhouse (1998) of female doctors reported covert, yet definite, career limitations. It appeared that women doctors were excluded from certain medical disciplines such as Orthopaedics and even Obstetrics and thereby suffered from sexual stereotypical ideas such as being considered a 'little woman' or as being a 'promotion risk' due the possibility of needing time off to have children or to stay at home with sick children.

Medical practitioners and nurses, then, are each affected by covert violence in their workplaces. They are subject to patients who are anxious about their admission or appointments, who may be adversely affected by drugs or alcohol, and who may be biased as to the gender of the nurse or doctor who treats them initially.

Another group of workers- those of emergency services – have also been shown to experience covert violence whilst going about their work.

2.9.4. *Emergency workers*

A Finnish study by Hook and Huttunen (2007) of 468 emergency workers reported that 73.3% of firemen and other emergency

workers had reported they were either threatened or the targets of other forms of violence.

A Swedish study by Suserud, Blomquist and Johannson (2002) reported that, of the 66 paramedics surveyed, over 75% were victims of verbal abuse. Similarly eight hundred and thirty (830) Australian paramedics were surveyed by Boyle, Koritsas etal (2007) and from the data collected, it was found that, in the previous twelve months, 82% had experienced verbal violence, 55% had been victims of intimidation, and 17% had been exposed to episodes of sexual harassment.

2.9.5. _Other occupations_

Workers in other occupations have also been studied and are victims of covert violence. These occupations include workers in the sex industry, Selb, Fischer and Najman (2003), drivers, Boyle, (2009), construction workers, Loosemore and Chua, (2001), call centre staff, D'Cruz and Noronha, (2009), those in the military, Harrison, (2003), and fruit pickers , DePedro, et al., (2008).

A 2003 Queensland study of two hundred and forty seven sex workers by Selb, Fischer and Najman (reported in 2009) concluded that they were often victims of covert violence such as verbal abuse, threats of physical violence and stalking.

An American survey of drivers employed by the Travis County Department of Transport and National Resources in 2008 by Boyle (2009) received one hundred and fifty six responses to a questionnaire on working conditions, and reported covert violence commonplace between management and drivers and between drivers themselves. Rosters were changed without notice and verbal abuse was common. Despite there being a book on codes of behaviour that all workers were given at the commencement of their employment and to which they were all expected to adhere, not all

did, and because of the huge bureaucracy that characterised the department. Many managers knew about the episodes of covert violence but did not take complaints seriously. Others, even with proof, did not feel it necessary to actually deal with the problem, others simply were unaware (or chose to remain unaware) of the problem entirely.

Loosemore and Chua (2001) reported that up to 40% of Asian construction workers employed in Australia by Australian companies were victims of intimidation and limited employment rights such as Occupational and Health issues, wage parity with Australian workers, and were victims of issues of isolation where Asian workers were not included in general conversations amongst employees.

Research by D'Cruz and Noronha (2009) surveyed call centre workers, both male and female, in Mombai (34 agents) and Bangalore (25 agents). Covert violence by managers and colleagues was rife, however, because of the material gains possible with regular work which was so important both financially and socially, the workers seldom complained and so were thereby participants in their own oppression. Their work load and expectations by managers were extreme and mostly unrealistic, resulting in workers becoming ill and yet reluctant to take time off working, longer hours of work to achieve the numbers of calls expected. There was competition between workers that resulted in further anguish and feelings of incompetence and greater stress.

The issues of sexual harassment and discrimination are evident in studies of occupations such as the military and in occupations where women and men compete for equality in pay and hours worked. A Canadian study of one hundred female military personnel by Harrison (2003) reported that a majority had been victims of covert violence by male personnel in the previous year. They had had to endure sexual harassment comments, the hearing, and being the butt of sexually explicit jokes, and having fewer opportunities for promotion.

Over nine thousand cases of discrimination and harassment were received by the Queensland Working Women's Service from 2001-2004, (Looseman and Chua, 2004). The workers felt that they were discriminated against over issues of age (males were considered more able to work longer hours and over more years), sex, race (non-whites targeted), pregnancy and family responsibilities. They believed that in general women were offered poorer quality jobs and those who worked part-time were given fewer opportunities for advanced training and had less bargaining power as far as actual working conditions were concerned.

A Spanish study of three hundred and ninety six people in the fruit-picking industry was reported by De Pedro, Sanchez Navarro and Ezquierdo, (2008). Of these 61% were men, and most were single people with a low educational level, and on time-limited contracts. They reported incidences of workplace mobbing, detrimental comments, malicious gossip and threats of violence from other workers. There was a 'silent epidemic that causes job dissatisfaction, psychological distress and psychosomatic and physical problems' (p220). These manifested themselves in vague aches and pains (30%), headaches (23.8%), general fatigue (27.5%), excess leave taking (26.3%). Other manifestations of the stress experienced included breathing problems and sleeping and eating disorders.

2.9.6. Summary

This list of other occupations where incidences of covert violence have been reported and studied is far from exhaustive. As in the Nursing profession, not all episodes of covert violence that are experienced by workers are reported. Some of the reasons for non-reported are similar to those in Nursing such as the threat of unemployment or loss of hours, the unwillingness of being a 'whistle-blower' or poor colleague, being considered petty, childish or

neurotic, financial concerns of the workers' families and lack of opportunity to secure other employment elsewhere. From the literature reviewed the researcher believes that the proposed model of covert violence in Nursing as outlined in diagrammatical form in 2.10. may be applicable to most employment situations where covert violence is evident or even endemic.

2.10. Model for covert violence in nursing
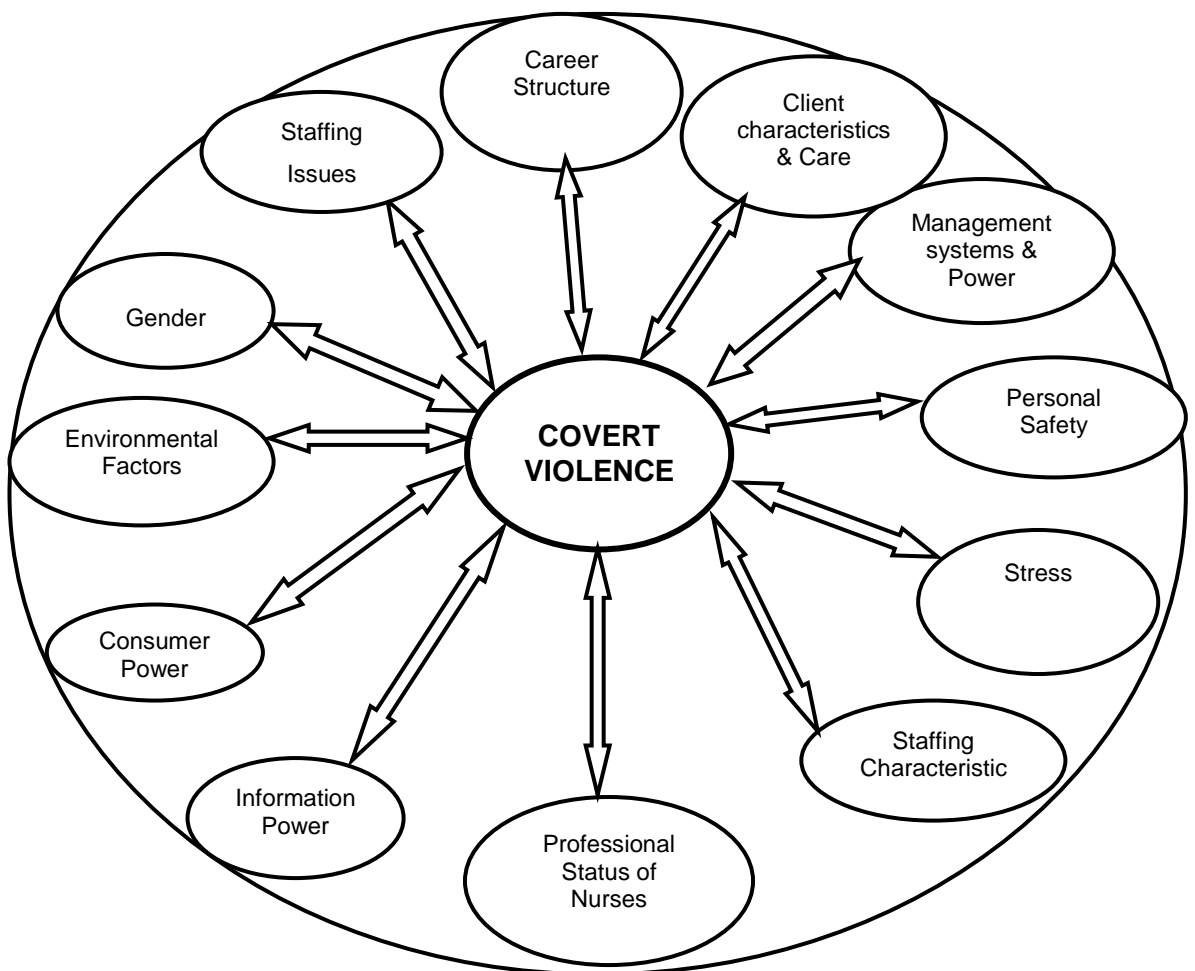
Figure 1. Model of covert violence in nursing

2.10.1. *Introduction*

This model was developed to answer the research questions which were:

- What are the characteristics of covert violence experienced by Western Australian nurses?
- What are the causes of covert violence experiences by Western Australian nurses?

From the literature review and personal experience when working as a registered nurse, the researcher established the above proposed model to highlight anticipated causes of covert violence in nursing. From the international data it is evident that clients, staff and management all have some input into the incidences of covert violence in their area of work. Based on published literature it was identified that all the characteristics may be a result of changing values in society in general and with nursing in particular and that they all work together to create a disturbed and often dangerous workplace. Each of the factors in this model was investigated in the research respondents' stories with the aim of lessening the incidence and effects of this problem on the occurrence of covert violence in nursing.

2.10.2. *Career structure*

In Australia during 1987-1988 there was a change in nursing management structure and promotion pathway for Western Australian nurses which was called a Career Structure. This change may have contributed to some of the present day causes of covert violence directed at nurses. With the implementation of this career structure was the requirement that all new nurses were educated in a university with a degree in nursing as the basic requirement for registration as a registered nurse or midwife.

Prior to the introduction of the Nursing career structure, most Registered Nurses in Western Australia had hospital-based training, rather than university education. Historically nursing staff were promoted in relation to the time they worked on a particular ward or specialty. All nurses basically had the same hospital-based education and obtained further qualifications in their specialties over time and as the opportunities arose. Today, length of time in a specialty is not necessarily a reason for promotion. University-trained nurses are often preferred to hospital-trained nurses as far as general employment is concerned, and further education is offered to those who are considered 'better value' such as younger nurses who would be less likely to leave the profession, full-time workers and those with a recognised ability to study. Lepage and Beckowitz, in Shaffer, (1997) concluded that aggression occurs when an individual is prevented from reaching a goal – in a nursing situation it could mean being overlooked for a promotion or a particular position such as area manager or even the frustration at not being chosen to attend specific further-training lectures, etc. Doyal (2007) writes of a crisis that may be developing in nursing because of its highly differentiated career structure and education policy that has resulted in general discontent among nurses leading to poor patient care, job dissatisfaction and an inclination to earlier retirement or complete change of career. Hutchinson, et al., (2004) concluded from their Australian research that the career structure in nursing had a profound effect on the occurrence and consequences of bullying amongst nurses. This study looked at these two different types of nursing education to see if there was any real bias for or against either form of study, hospital-based or university-based qualifications as far as career opportunities are concerned.

A second issue that has been identified from previous literature is that clients and their families have specific characteristics that may affect their response to illness and to the staff they encounter at a health campus.

2.10.3. *Client characteristics and care*

Shields and Wilkins (2009) concluded from their Canadian research that client characteristics could include socio-economic factors, issues of specific concern for themselves or their relatives, age, gender or race or disruptive and violent behaviour due to drug or alcohol use or abuse. Madden, (1985) wrote of a person's family lifestyle contributing to their attitudes towards others, including aggression and need for immediate attention, which may spill over into their experience of being in hospital. Aggression may be directed towards nursing staff in the belief that they, the nurses, are responsible for their having to wait to be seen by medical staff, for their place in the theatre lists, and having to wait to be discharged. This research considered if the types of clients and their individual characteristics had an effect on the participants in this study.

A further consideration for this study was that of the influence of the management systems of hospitals and health centres themselves on both staff and clients.

2.10.4. *Management systems and power*

It was anticipated that some consideration be given to management systems within hospitals or clinics regarding issues of covert violence and response. Hutchinson et al., (2010) researched Australian hospitals and concluded that their organisational characteristics were in part responsible for the development and continuation of a culture of bullying among nurses. The 'power' manifested itself in the extent to which such cases were or were not investigated and how they were dealt with. Brockensha, (2006) and Lindy, (2009) both equated the management systems with the 'acceptance' of bullying between staff, from both a managerial level and from colleagues. Felblinger, (2007) concluded that there was a deliberate desensitizing to the

issue of bullying by managers in order to diffuse problems, even ignore them for as long as possible.

This factor was included in the model of covert violence as published literature indicated that management system and power were factors that influenced the occurrence of covert violence. This research sought to identify if there was a marked difference between small workplaces, such as health clinics, rural first aid stations and large city or rural hospitals. These factors consider the management systems in general, issues that appeared to separate staff from management as far as lack of information sharing, lack of opportunities for nurses to be involved in hospital or clinic policies (Johnston, et al., 2009) or situations where the reporting of incidences of covert violence towards staff were either ignored or not fully investigated or if staff who report covert violence were treated unfairly.

Tomey (2009) discussed management systems and power in her research of healthy workplace environments. She believed there was a correlation between positive workplace management and retention of staff, better patient-care outcomes and fairer workloads. Campbell (2010), on the other hand, is concerned that there are still control and class issues that affect the nursing labour process.

The next issue included in the model of causes of covert violence in nursing was that of staff personal safety. Occupational Safety and Health issues were thought to be possible triggers to covert violence in the workplace.

2.10.5. *Personal safety*

This could include general issues of maintenance and actual construction of a ward, clinic or office, such as lighting, 'hidden' corners, lack of personal or ward alarms, seating and bedding

arrangements and equipment safety. Hesketh, (2003) reported risk factors such as working alone, having access to drugs, and the provision of care to people in distress. The researcher had found this to be of importance, especially when working alone on an early morning shift in an area quite distant from the rest of the hospital campus. Flynn and McKeon, (2009) concluded from their research that concern for personal security by hospital staff was one was one of the main issues of discontent amongst nurses.

Opie, et. al., (2010), studied the effects of working in remote areas and alone on over 1000 registered nurses in Australia. For many personal safety and fear resulted in Post Traumatic Stress Disorder. Wilkinson and Huntington (2009) also studied nurses who worked alone such as District Nurses and their research findings echo that of Opie's.

In a hospital setting, though, the challenges may be different. There are certainly occasions when a nurse is working alone, but the main issues that affect nurses' mental and physical health are the demands of the actual organisation with increased numbers of patients, early discharge policies, shift work, long hours and overtime expectations that may jeopardise a nurse's safety and well-being.

Another factor of interest was that of the influence of the need to continuously upgrade information and nursing practice on the work stresses of staff.

2.10.6. *Causes of stress*

The Collins English Dictionary (Fowler and Fowler, 1985, p173) defines 'quality' as 'attribute (degree of) excellence' and Management as 'success in doing' (p131). Having successful management practices is important in companies that wish to continue to strive for further business potentials. To accomplish this

in nursing the concepts of Best Practice and Quality Assurance are implemented ensure that each procedure undertaken at a clinic or hospital has been studied and policies adapted and constantly being updated to ensure that a workplace is current with their practices and procedures. Staff members need to have a genuine input into discussions about best practice and how it is implemented in their workplace. They also need opportunities to constructively criticise the systems that are in place and the way the best practice manuals are written and distributed throughout the health service. This does not always occur.

In a 2009 Canadian study, Rankin and Campbell concluded that with hospitals continually stressing the efficient use of resources with quick patient turn-over and increased workloads, there are corresponding tensions and challenges that alter nurses' concepts of their work and value. These researchers reported 'subtle expressions of disquiet' which can lead to staff friction and bullying (p40). They conclude by stating that 'When the full weight of institutionalised authority is accorded to health information and to the objectified decision-making it supports, nurses' professional knowledge and judgement are continually overridden and subordinated' (p41).

The individual characteristics and competency of staff members, and how they interact with other staff may also be a factor in workplace violence.

2.10.7. *Staffing characteristics*

A Victorian (Australian) study into workplace violence by Osborne (2009) highlighted that it is those who are different that get bullied. They include 'foreigners', loners, temporary staff, nurses who were either younger or older than the average nurse on a ward or unit. Those who stood out for having a different set of values, either religious or as a carer, and those whose competency resulted in the

acquisition of awards, thereby preventing them from 'conforming to a norm of mediocrity' (p24).

Paliadellis and Cruickshank, (2007) also concluded that the lack of support by colleagues towards the victims of covert violence actually increased its effect on the victim and on the workplace environment itself. Lack of support may be the ignoring of a victim's experience or the refusal to 'dob in' the perpetrator, although, in many cases, the other colleagues have been victims of that perpetrator as well.

Other literature on covert violence in nursing by Duffy, (1995), Wilkie, (1996), Leigh, (2003) and Roy, (2007), state that the changing state of nursing itself and how people, the public or other professionals, view this change may be an issue in how they respond to each other.

2.10.8. *Professional status of nursing and nurses*

In Bakker, (2003), there was evidence that medical staff were the perpetrators of covert violence against nurses who were hospital-based trained, and often against nurses in general, treating them somewhat as handmaidens that should follow every instruction they gave without protest or interference. It was anticipated that this current research would show if this was still the case, or whether doctors, nurses and other members of society now viewed nurses and the career of nursing differently.

2.10.9. *Information power*

Johnston, et al., (2009) concluded that there was a power/powerlessness situation with management in that they were both victims of the economic and political changes that affected the running of hospitals and health services, as well as being responsible for the implementation of the changes. They were not always in a

situation where they could disperse all the information to their staff. This often resulted in discontent and even anger being directed towards them, and yet they were not able to adequately solve the apparent information gap.

A second part of this information power was that of a client's level of information about their illnesses and a hospital's duty towards them. Johnston, et al., (2009) conclude from their research that the availability of medical information on internet sites, legal stories of mistreatment and, often, incorrect information given by well-meaning friends and relatives may make a patient unwilling to accept the treatment offered by nurses or doctors, resulting in apparent aggression by the patient. The threat of being reported for any perceived breach of care is one aspect of bullying.

Along with apparent information power there is a need to consider its effect on the patients and their experience as consumers.

2.10.10. *Consumer power*

Research by Ortega, et al, (2009) identified that with a greater emphasis on patients' rights and satisfaction, patients are becoming more abusive and more demanding. As well as consumer power, the actual physical environment of the health service or ward or unit can affect the incidences of covert violence.

2.10.11. *Environmental factors*

Environmental factors that can affect the incidence of covert violence include the warmth and light of the workplace in general, where that workplace actually is – in a large hospital or isolated in a country town or village, or in an industrial situation – and how these affected the nurses and the clients with whom they have to deal. Boyce, in a

2009 Masters Thesis developed a model for workplace violence prevention across a spectrum of workplaces, including nursing. Her recommendations were that all workplaces fit physical safety devices such as panic alarms, have adequate lighting, staffing ratios and, where necessary, video surveillance cameras. She also recommended that there be an ongoing flow of employee traffic through the workplace in order that staff are safe and are seen to be so. The issue of gender may also be a problem.

2.10.12. _Gender issues_

Till, (1980) concluded that all people in a public service situation were liable to being victims of gender, religious and social bias. Sohi et al., (2008) discusses the idea that a male domination theory still holds true in the hospital situation. Stereotyping continues the tradition of male doctors and female nurses. From his research, it would seem that neither patients nor nurses have quite dispensed of this concept.

The final factor in this model of covert violence is that of specific staffing issues and problems.

2.10.13. _Staffing issues_

Research by Flynn and McKeon (2009) concluded that the incidences of workplace violence could be addressed and solved in part by better security around health campuses, and through optimum skill mixes of staff. Shiimizutari, Obagiri and Ohya, (2000), Kivinski, et al., (2007), and Stone, Du and Gershor, (2007) all equated poor staffing levels, the use of temporary staff and the expectation of staff doing overtime to high levels of stress amongst nurses which, in turn, resulted in aggression and feelings of low self-esteem amongst and between staff.

This research considered whether in a general hospital or clinic, there were episodes of covert violence between nurses and patients and between nursing colleagues that arose because of staffing issues, the number of staff employed, the seniority of the staff, and if criticism or reporting of incidences of covert violence lead to threats of unemployment or changes of employment status.

2.11. Summary

The model of covert violence in nursing, developed from published literature, was used to identify and analyse the description and characteristics of covert violence as experienced by the fifty Registered Nurses who participated in this research.

It is evident from this review of published literature that nurses experience a high level of abuse and covert violence in the course of their work, as do workers in other occupations (Canadian Public Health Association, 2002). In most cases this is not only unpleasant but also against the law. However, in relation to nursing in particular, over generations not all nurses have spoken out on this topic and have, themselves, assisted in the perpetuation of the problem emerging from a global perspective (Felblinger, 2007). Whether that violence is verbal or intra-staff, nurses have maintained their silence either to protect their jobs or to discourage colleagues from belittling them further. Suffering in silence is what nurses have done for years. Occupational Safety and Health laws are in place to see that this changes, but management and the whole philosophy of Nursing may have to change before covert violence is no longer a common occurrence in nursing.

A research study of Western Australian hospitals conducted in 2006 (Tillett) showed that violence experienced by health care workers

was of epidemic proportions. This research study, however, concentrated only on patient to staff violence. Similarly, Prior (2008) reported that patient physical violence against staff had increased by 350% in the previous five years with 240 incidences being reported each month at Royal Perth Hospital Western Australia. None of these studies looked at more than patient to nurse incidences of physical violence. None of the research studies reported in a comprehensive literature review answered the research questions of this study, which were:

- What are the characteristics of covert violence experienced by Western Australian nurses?

- What are the causes of covert violence experienced by Western Australian nurses?

This literature review has highlighted the problem of covert violence in the Western Australian and other health systems by reviewing published literature related to covert violence. This literature identifies that workplace violence in hospitals and other health care settings occurs for many reasons already discussed including staffing issues, client and staff characteristics, stress levels and their effects on both staff and patients, the juxtaposition of power and powerlessness as far as staff, patients and visitors are concerned, environmental factors, gender issues, the nursing career structure and professional status of nurses.

Covert violence in the workplace remains a major reason for nurses to consider early retirement (Stone, Du and Gershon, 2007), and even a complete change of occupation (Martin, 2008) because covert violence is still an issue that is handled poorly by staff and administrators alike. It is anticipated that recommendations from this research, based on the literature review and research findings, will give nurses power to speak out against the covert violence they experience in their workplaces. This power will, in turn, help to initiate changes to their actual working conditions such as work

loads, roster anomalies and horizontal violence as well as coping strategies for issues of patient and relatives aggression.

The published literature and the model developed for identifying causes of covert violence in nursing were the basis for the phenomenological study for this research. This methodology has been discussed in the next chapter.

3. RESEARCH METHODOLOGY

3.1. Introduction

Chapter three outlines the design and methodology for this research into incidences of covert violence that have been perpetrated towards nurses in their workplaces. The chapter explains the Hermeneutics and qualitative research approach, the participants, and how the data was collected and interpreted.

3.2. Research methodology

Phenomenological study as a research method was formulated in Germany in the late 1880s (Wilkes, 1991). Phenomenology seeks to gain understanding and meaning of a particular phenomenon. It acknowledges the importance of sharing in order to develop a group identity – in this case, the identity of a nurse, what he/she stands for in a social sense and the role played by a nurse in a professional sense. By using the phenomenology research method, nurses are accepted as people with personal views, concerns, fears and ideals, not just passive objects of impersonality.

3.2.1. *Van Manen's Hermeneutic philosophy*

Hermeneutic phenomenology reveals the nature of human experience, so that it can be made more meaningful (Van der Zalm & Bergum, 2000). This approach enabled the experience of covert violence to be understood in the ways in which it occurs in nursing, including intimidation, humiliation, ostracism and anger between nurses and between nurses and members of the public.

Van Manen (1997) identified six elements of a hermeneutic process:

1. turning to the nature of the lived experience;

2. investigating experience as we live it;

3. reflecting on the themes of the phenomenon;

4. describing the phenomenon;

5. maintaining an orientation to the phenomenon; and

6. balancing the research.

These elements of the philosophy were applied to this research in that the participants had offered written and verbal experiences of the covert violence they had experienced in their workplaces. Each not only described the phenomenon itself, but also offered some insight into why such events occurred and how they, the nurses, reacted to the experiences. On speaking to some of the participants the themes that have been extracted became evident. Once the phenomenon of covert violence was elicited and the themes gleaned from the data received, pattern matching was used to identify the characteristics and causes of the incidences reported.

3.3. Qualitative research

Qualitative research, defined broadly, is 'any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification.' (Strauss and Corbin,1990). There are five main types of qualitative research:

- case study where a specific phenomenon is studied using a single case example;
- grounded theory in which data is acquired by a participant-observer;
- phenomenology, describing the structures of experience as they present themselves;

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- Ethnology, focussing on sociocultural phenomena in a specific community; and

- historical, the collection and evaluation of data related to past occurrences in order to test hypotheses concerning causes, effects, or trends of these events that may have an effect on current and future events.

Miles and Huberman (1994), outline three main types of qualitative data collection. The first is interactive interviewing which is tape recorded for data analysis, where respondents are asked to verbalise their experience of the phenomenon that is being studied. The second is written descriptions of the phenomenon by the participants. The last is descriptive observation by the researcher of verbal and non-verbal behaviour of the participants. In this research study the method used to collect information to the research questions was interactive interviewing, but some chose to use mostly written descriptions of experiences because some nurses felt less threatened writing about their experiences rather than having face-to-face questioning, also they could write in their own time at their own comfort. This combination of data collection methods enabled nurses to participate regardless of where they worked, for example, those in country towns and on worksites around the State.

3.3.1. *Features of qualitative research*

Qualitative Research is a term for investigative methodologies described as ethnographic, anthropological, naturalistic or field or participant observer research. It emphasises the importance of observing variables in the natural setting in which they occur.

Detailed data is gathered through open-ended questions that require direct quotations. The interviewer is an integral part of the investigation (Jacobs, 2005). It differs from quantitative research

which attempts to gather data by objective methods to gain information, comparisons and predictions, and attempts to remove the researcher from the investigation (Smith, 2000).

Patton (1990), Bendoliel (1984), and Leininger (1985) describe characteristics of naturalistic qualitative research. They are:

- qualitative research reports are descriptive, incorporating expressive language and the 'presence of voice in the text' (Eisner, 1991, p36);

- qualitative research has an emergent (not predetermined) design and outcome;

- qualitative research uses the natural setting as a source of data. The research maintains an 'emphatic neutrality' (Patton, 1990, p55) whilst observing and interpreting the settings;

- qualitative research has an interpretive character seeking to discover the meaning of events have for the individuals who experience them.

In this research open-ended questions were provided to the participants which resulted in their own descriptions of the experiences they had encountered in their workplaces. They expressed their feelings in their writing and in their speech for the audiotapes. This also gave opportunity for the researcher to discover the meaning of these events and how they have impacted on the participants, their careers and, in some cases, their families.

This research shows methodological and conceptual rigor with a focus on achieving answers to the research questions which were:

- What are the characteristics of covert violence experienced by Western Australian nurses?

- What are the causes of covert violence experienced by Western Australian nurses?

The use of naturalistic qualitative research methods has enabled the presentation of logical findings from the stories obtained from nurses who participated in this research study and provides the evidence on which the research interpretations and understandings are based.

3.4. Sample

The target population under study was registered nurses who were members of the Australian Nursing Federation. They were registered with the Nurses Board of W.A. as either Division 1 (general registration with a Bachelor of Nursing degree or hospital trained nurses) and represented general hospitals, country hospitals, small clinics, industrial worksites and private agency nurses.

The data collected, according to O'Brien (2002), is not determined by the number of participants, rather in the richness of the data collected. With this in view, fifty people responded and this was considered adequate to obtain suitable data as data saturation was obtained.

Of the fifty respondents, forty were female, ten male, and the average length of nursing experience was 12 years. Most worked in city/suburban hospitals, two were employed on industrial sites and two were from country health clinics, not hospitals. Eight worked in country hospitals. Five were nursing agency staff employed throughout the metropolitan area.

3.5. Demographics of participants

The demographic characteristics of the sample are presented in Table 2. Fifty nurses participated in the study and were aged from 21

to 65 years. Most (30) were university-trained, 20 had had hospital-based training. This diversity offered interesting insights into how nurses of different ages and training backgrounds are identifying and coping with issues of covert violence in the workplace.

3.6. Recruitment and sampling procedures

It was initially planned to elicit data through the publication of an article in *Western Nurse* but this was not possible, so information was collected through word-of-mouth at nursing conferences and lectures. Obtaining volunteer research participants began with a discussion at various nursing seminars in which the researcher was given a short time to introduce her proposed study. There was a certain amount of snowballing from then on. Snowballing is when study subjects recruit other subjects from amongst their friends or colleagues (Davis, 2004). It is often used to gain data from 'hidden' populations such as drug users, prostitutes or where 'public acknowledgement of membership in the population is potentially threatening thereby producing low response rates' (Heckathorn, 1997, p.175). Nurses are often reluctant to speak out against their colleagues or against their workplaces for fear of being found to be 'childish' with their complaints or or losing their employment. Salganik and Heckathorn (2004, p.195) recommend this method as it can be done 'cheaply, quickly and more easily than other methods in use'. For this study participants were asked to speak to their colleagues and to either contact the researcher by mail, telephone, email or in person. For those requesting it, a personal interview was arranged.

3.7. Interview technique

The initial questions were open-ended encouraging the interviewee to actually lead the conversation (Moyle, 1997). In this way the participant's story was told in their own words. The participants were

aware that the researcher was a registered nurse and so this form of interview permitted the researcher to have something of a conversational role whilst enabling the researcher to elicit responses from the participants. Participants were able to voice their opinions, feelings and views freely.

The open-ended questions were asked by the researcher either directly or on the distributed form. Demographic data was collected that included the participant's place and unit of work, their age and gender, and how long they had been in their current position. This format was used originally by the researcher for the research pilot study and was replicated to further investigate the topic of covert violence.

3.8. Pilot study

A pilot study was conducted involving the collection of stories of experiences of covert violence from forty nurses who were working at one health service (Bakker, 2003). Significant statements were extracted that pertained specifically to incidences of covert violence. These statements were organized into clusters resulting in four themes. The four main themes that emerged from the pilot study data were offensive behaviour, verbal abuse, bullying and unfair workloads. Four groups of people were also identified from the data as being 'abusers'. They were patients, patients' relatives, colleagues and medical staff. Correlation between the data collected from the pilot study and from the results of the research study was noted and are described in chapters 4 and 5 of this research report.

3.9 Research Questions

The questions were designed to facilitate ease of answer. The questionnaire was in two parts, the first to determine the participant's work site and position, and the second to enable the participant to

describe the incidences of covert violence they had experienced. The first four questions were as follows:

1. In what employment area do you work (e.g. large/small city/suburban/country hospital, clinic (private/public) or industrial site)?
2. Gender.
3. Length of time in present position.
4. Length of time in nursing.

In the second part of the document, the questions asked were:

1. What forms of covert violence have you experienced at your place of work?
2. What caused/contributed to these episodes?
3. How were these episodes dealt with?
4. Did you report these incidences? To whom?
5. What support have you received from management/senior staff?
6. What ideas do you have to reduce the incidences of covert violence?

The interviews continued until the participants felt that they had told their stories and descriptions of the phenomenon. One researcher conducted all interviews that were audio-taped and transcribed. Having one researcher conduct interviews ensured the reliability of the information collected. Field notes were written immediately after each interview. The participants were given a copy of all transcribed material to check its accuracy and to have the opportunity to correct the transcription if they felt the original transcript was not accurate. This ensured data validity and reliability. All participants interviewed were offered a follow-up interview, although none were requested. Once the initial analysis of the data was available, the transcribed interviews were analysed using pattern matching for the purpose of

discovering different themes that occurred when answering the research questions.

Eighteen nurses wrote their information rather than attend an interview and sent their open-ended questions' answers by mail to the researcher or gave them directly to the researcher. Either way, the language used in the data reflected the meanings embedded in each experience. Stake (1978, p.6) explains that 'naturalistic generalisation' develops as people learn about how things are, why they are and how people feel about them. These generalisations may become verbalised, passing from tacit knowledge to proposition…but are…never formal.' This study, then, was an interpretist model using qualitative research methods. It relied on naturalistic generalisations to collate the data into specific categories.

3.10. Data analysis – steps of initial coding

Once interviews were completed and written submissions collected, the following steps were implemented:

1. interviews were transcribed;

2. transcribed interviews were read, reread and compared with the original tape recordings;

3. each transcription was then given to the person who provided the information to check for accuracy. Any changes required to improve accuracy were made.

4. written submissions were collated;

5. stories received were reflected upon and potential themes were identified;

6. words, phrases and figures of speech were coded according to themes;

7. contrasting and comparative cases were recorded under the correct theme.

Tesch (1990), cited in Coffey and Atkinson (1996, p.10) describes key characteristics of qualitative data analysis thus:

> Analysis is a cylindrical process and a reflexive activity; the analytic process should be comprehensive and systemic, but not rigid; the data are segmented and divided into meaningful units, but connection to the whole is maintained; and data are organised according to a system derived from the data themselves.

With this as a basis there was an attempt to understand a very complex issue with great significance, social, professional, personal and economic. The content of the collected data was analysed using pattern matching. Tellis (2003, p.1) defines pattern matching as a major mode of analysis where data collected from various sources are processed to determine if there are repeated important themes emerging from the data. Matching patterns allow the researcher to adequate describe the events under study. The initial findings were offered to the participants to comment on, either written or verbal, and for any feedback or further validation. The themes identified form the basis for the next chapter of this research report.

3.11. Narrative analysis

The nature of the data and its details allowed the use of narrative analysis. Holloway and Jefferson (2000) suggest that, when listening to a story, one focuses on the person speaking and the stories themselves help to understand the subjects better. The stories of covert violence were investigated in terms of the cultural context they display. They also offered the participants opportunity to be empowered sufficiently to speak out about the issues covert violence and how it has impacted on their professional and personal lives. The stories were compared with each other to enhance understanding.

3.12. Validity

This issue has been dealt with by many authors including Lincoln and Guba (1985), Whyte (1984) and Leininger (1985). According to Leininger, (p.68), validity 'refers to gaining knowledge and understanding of the true nature …of a particular phenomenon...and reliability focuses on identifying and documenting recurrent, accurate and consistent or inconsistent factors.' Validity in scientific research is important. It is a check that the research data represents truly the phenomenon being studied. This can be done using four criteria:

- Credibility. This is described by Patten, (1999) and Byrne, (2001). It is achieved when those who experience the phenomenon recognise descriptions and interpretations of it. The findings of the data analysis were checked against the other data and with already-published literature on covert violence in nursing. Commonalities, if they existed, were then established.

- Aptness. Rosenthal and Rosnow, (2001) and Rogelberg, (2004) refer to aptness as how well the research 'fits' other comparable situations. These were checked against other published data to see if any similar themes emerge.

- Auditability. Literature by Rea and Parker, (2005) and Miles and Huberman, (1994) state that this occurs when an outside researcher can follow the trail of the original researcher. Information was gathered using field notes and concerning decisions made in the research. These provided all details of the data collection and analysis.

- Confirmability. This is said to be attained when all the above three criteria have been met, Miles and Huberman, (1994) and Rodeghier, (1997). In order to achieve this, all data was checked against already-published data on the topic and commonalities recorded.

3.13. Reliability

In experimental sciences, reliability is the extent to which the measurements of a test are consistent when repeated over identical conditions 'An experiment is reliable if it yields consistent results of the same measure. It is unreliable if repeated measurements give different results. It can also be interpreted as the lack of random error in measurement.' (Rudner & Shafer, 2002).

As each registered nurse was asked to document incidents of covert violence that they have experienced in their workplace, then the information collected must be taken as being reliable. Also, the very fact that nurses were prepared to speak out about their experiences meant that the incidences had a definite and lasting effect on them.

To further check the reliability of the analysis of the collected data, an independent researcher, who was not a nurse, was asked to read the transcripts and listen to the audio tapes in order that the independent researcher may generate a theme for each research participant's story. Consensus was achieved between the two researchers who interpreted each theme from the nurse participants' stories. The same themes were identified for all of the stories. This provided inter rater reliability.

3.14. Ethical Considerations

The ethical approval for conducting this research study was granted by Edith Cowan University Ethics Committee. All participants were given written information as to the aim of the study (see Appendix A.). This was to ensure beneficence and justice. (Burns and Grove, 1993). Participants were provided with the reason for the research, the anticipated benefits of it, and the actual data collection method. Participants were made aware, both verbally and from information written on the consent form, that participation in the study was voluntary and that they could withdraw from the study at any time

and at no cost to them, either financially or morally. They were assured of anonymity and confidentiality and that all data collected would be stored correctly according to Edith Cowan University (ECU) guidelines, with access only available to the researcher and the principal research supervisor. The participants were also given the opportunity to choose a pseudonym, but most were comfortable for the researcher to use their first names rather than a suggested code or number. Research participants were also offered the opportunity of counselling should the need arise. All audio tapes were given a number. Names were not recorded and no workplace was identified.

Consideration also applied to the researcher. With reflective journaling the researcher responded to the stories and themes thus emerging. The researcher believes that it was important, therefore, to make it clear to participants that the researcher would not comment on themes and actual data collected.

The data was collected according to Edith Cowan University guidelines with all written information stored in a locked filing cabinet to which only the researcher had access and it will be stored for five years. The audio tapes, once transcribed, were deleted and all identifying data was removed during the transcription of the interviews. This is in accordance with the ECU *Guidelines on the Responsible Conduct of Research and Scholarship, March 2010.*

3.15. Limitations of the study

A limitation of this study was the concern of nurses to actually speak out about the issue of covert violence. They needed to be reassured that any information given to the researcher would be securely stored, have no identifying information as to the nurse or workplace on either the audio tapes or the written transcripts. They were made aware that they and their data could withdraw from the study at any time with no adverse connotations to them.

This type of data collection may attract some bias with recall issues and it was anticipated that those who responded to the open-ended questions would be either specially passionate about the topic or had been affected greatly by a particular experience which would enhance reliability. The anonymity of the data might have also been seen as a method of acceptable 'complaining' about a specific issue or on the topic of covert violence in general.

The identification of themes in this research may at best be seen as an oversimplification of the apparently widespread problem of covert violence in nursing and so in themselves were reduced to generalisations, but the stories obtained from nurses are meaningful and rich in experiences.

3.16. Summary

This chapter has described how a combination of hermeneutics and qualitative research was used to collect data for this research, how the participants were selected and how the data was collected and analysed and cross checked to obtain inter-rater reliability. Issues such as validity, reliability were discussed and limitations and ethical considerations were outlined. The next chapter provides the research participants' stories and answers to the research questions.

4. WESTERN AUSTRALIAN NURSES' EXPERIENCE OF COVERT VIOLENCE

4.1 Introduction

This research was designed to address two research questions. They were:

1. What are the characteristics of covert violence experienced by Western Australian nurses?

2. What are the causes of covert violence experienced by Western Australian nurses?

This chapter discusses the profile of participants in the study and compares the results of the research study and the Pilot Study. It provides the answers to the respondents' interview questions and the two research questions.

4.2. Profile of participants for this study

Fifty nurses responded to the research question, 'What incidences of covert violence have you experienced in your workplace?' This question was asked to assist with identifying Western Australian nurses' experiences of covert violence and the characteristics of this violence in order to provide the answer to the first research question. This chapter records stories told in the words of the participant. Many areas of nursing were covered – Theatres, Mental Health, Medical, Surgical, Maternity and Outpatients. This research also included nurses who worked in country hospitals, industrial worksites and small rural nursing posts.

The following table shows the time spent in nursing by the respondents.

Table 1: Comparison of years spent in nursing by respondents

Year of Service	Number	Percentage
0-5	6	12
5-10	10	20
10-20	20	40
20-30	10	20
Over 30	4	8

As can be seen, the most respondents in the research survey had completed between ten and twenty years in nursing. There would appear to be no specific reasons for this, except, perhaps, they are the most outspoken of nurses, or it may be that patients and their relatives might expect that seniority brings with it some aspects of 'control' over conditions such as waiting times, etc. and so become frustrated and discontented when the nurses cannot alter the situations successfully. The second comparison is one of gender.

A snapshot of Nursing (A.N.F. office, 2010) reported that in 2003 91.4% of nurses were female, 8.6% were male. In 2007 (the latest information available) 90.4% were female and 9.6% of nurses were male.

Table 2: Gender of respondents

Year	Gender	Number	Percentage
2003	Males	3	7.5
2003	Females	37	92.5
2010	Males	7	14
2010	Females	43	86

Table 2 is a comparison of numbers of respondents according to gender. The 2010 research figures show that twice as many males responded to the questionnaire in 2010 than in the 2003 Pilot Study. This could be that more males are continuing to enter the profession, or that they are being targeted for covert violence more often than before. It may also be that male nurses are becoming more vocal about their perceptions on how they are being treated by patients and other staff members.

4.3. Client characteristics and care

4.3.1. *Treatment schedules and waiting times for care*

Answers that the research respondents provided were analysed using pattern matching. Four different themes were identified by both the researcher and the interrator from the data collected. The themes identified were client characteristics and care, intra-staff issues, staff characteristics and management issues. The stories were placed in these specific themes, beginning with the theme client characteristics and care.

For this research study, the majority of data in this section concerned the verbal abuse of nurses by patients (20 incidences). Most involved swearing (10) and are believed to be the result of the general anxiety of the patient concerning his/her admission to hospital, treatment schedules and waiting time for surgery. All these were considered to be 'legitimate' concerns of the patient, but the fact that the nurses involved had no control over waiting times, theatre lists or the admission protocols meant that the nurses believed that they were blamed and criticised unfairly. An example of this is described by Patricia.

Patricia had worked in a surgical ward for over ten years. She reported being upset at the number of patients and their families who get agitated and then rude to staff because they have to wait for service.

'The local doctors, and even the surgeons who have them admitted, tell them their surgery is minor and will not take too long. This is true, but they still have to wait their turn. When I try to explain, many just get angrier suggesting that if they were private patients, they would not have to wait so long. I try to explain that even if they were private patients, they would still have to be on a surgery list, and therefore would still have to wait, but they maintain their anger. Some even walk out.'

Patricia's story is one of a perceived power/powerlessness process. According to the patients, the nurse has power over waiting times, etc, and they, therefore believe they are powerless to do anything about the wait. In reality, the nurse is governed by hospital planning and processes and in turn is powerless over the situation. Coupled with this is the poor, or indeed wrong, information given by doctors to their patients regarding the patient's proposed admission.

Having been given information by their doctors, most patients then have to organise family and work commitments and with this information proving wrong or insufficient, patients are often distressed when their planning is inadequate. Sohi, et. al. (2008), suggest one way to ease this situation is to have flexible admission times, so that patients have less real waiting time at hospitals or clinics prior to their actual surgery time. This may not be truly effective because the researcher has had experience with patients not informing a hospital or clinic that they would not in fact be arriving at the hospital or clinic, perhaps because they had changed their mind and no longer wanted the surgery, or in some cases, the patient had obtained the surgery at a different hospital. In these cases, it may be that there is then an unplanned 'gap' between patients' admissions, meaning that the operating list may be held up, possibly even cancelled. Nurses are themselves powerless against these issues, yet patients perceive them as being somewhat responsible for the hospital's or clinic's policies and work processes.

Peta's story is similar. Peta was a nurse working in the admission department of a suburban hospital. She reported on a series of people who choose to walk out rather than being admitted:

'I get tired of people constantly complaining about the length of time it takes to process their admission. I am tired of being harassed, sworn at, and blamed for the situation and for all the faults of the place, I understand that people get anxious waiting, but what can I do? Being rude or disruptive does not make the situation any better or the process any faster.'

Peta also wrote of an incident where a relative of a patient became verbally abusive because of the lengthy waiting time. The patient himself made no comment but

'The patient kept sighing and wriggling, and I think the relative waiting with him became as agitated with him as she did at the having to wait.'

Inadequate knowledge of actual surgical procedures may also pose a problem for the admitting nurse, as Kandie reported.

4.3.2. *Inadequate information provided to clients*

Poor information may also be responsible for a patient's lack of preparation for surgery. Kandie reported that she had had an experience in which a mother had given her four year old child a full breakfast prior to his admission for surgery. Initially the mother had admitted that he had been given water that morning, but after further interview by an anaesthetist, she admitted a whole meal had been given. Because of this, the surgery on the child was cancelled, and the mother was angry at the nurse, the hospital and the surgeon because she had taken time off work for the operation.

'So there I was being abused by the surgeon and also being abused very loudly by the mother, I felt I was in a sort of

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vacuum with everyone angry at me. The mother took her son and was abusing me by name all the way down the corridor, certainly not inspiring respect or confidence in me by all those who heard. I felt humiliated and almost apologised for my actions for the rest of the day, when all I was really concerned for was the child's safety.'

Claire also wrote of an incident where a patient (an adult) was asked to fast for a surgical procedure and did not do so. She had had tea and toast at home prior to being admitted to the ward. The anaesthetist then cancelled the operation and, not only did the patient complain, but the relative who had brought her in, became abusive to the nurse at the 'waste of time' she had faced now the procedure was no longer possible.

> *As if it was my fault! I didn't ignore the anaesthetist's request to be fasted. Why did I cop the blame? This happens so often!! Maybe nurses are fair game. The anaesthetists have final say as to who will be operated on, not the nurses. What about my wasted time – all the paperwork to have her relative admitted, all the observations I had to do? Just so rude.*

A second issue was over the swearing and general rudeness itself. Although it would appear to be part of everyday language, most nurses felt that it was actually unnecessary in the circumstances and were made feel demeaned by it. One stated (no.16) that if she spoke to a member of the public, a patient, in the same manner, she would be either sacked or severely reprimanded – *'One rule for patients, another for staff.'* Frustration over language difficulties or by a misunderstanding of directions was also expressed by patients' swearing (3 cases described). Again, the concern of the nurses was that they were not personally responsible for the situations and yet felt victimised and offended by the language.

Patient personal misinformation or lack of knowledge of one's own health problems can also lead to a form of covert violence against

nurses. Jenny cites a situation where an elderly lady was admitted, perhaps more of a 'social case' rather than a medical admission.

'She did not know what medications she took, not how often, did not really know why she was in hospital, but was really angry that she had been taken out of her own home and sent to hospital. She was angry and agitated throughout her admission, and did not appear to really care about what would happen when she was discharged. She had no real family and relied on neighbours to look after her and her house. She found the admission truly disrupting to her life. Perhaps she was afraid? However, she made life quite difficult for all who had anything to do with her, never happy with anything anyone did for her, and had to be watched to make sure she took her pills. Although the lady was sometimes quite nice, she made life so much harder for all the staff, meaning we all had to take extra time with her just so she would comply to her treatment regime – as if we didn't have enough to do than treat an ungrateful patient!"

A lack of personal health knowledge is common with health care clients. Donovan (1995) suggests that up to one third of all patients are not compliant with their medications or general care simply because they choose not to take responsibility for themselves. In the case of Jenny's patient, this may be part of her general lifestyle or perhaps a way of gaining some attention or acknowledgement. Perhaps she was afraid and felt powerless over her admission, over her state of general health, or even powerless over her social situation? Rollnick, et al., (2008) believe that these feelings of helplessness and powerlessness can be overcome by better medical questioning by doctors and nurses and by including patients in the proposed post-operative or post-hospital care.

A further issue, described by Ming, is that of rudeness that Ming believes is caused by changing society expectations of nurses and other public servants.

4.3.3. *Society expectations*

Ming reported that she believed she had noticed that especially teenage boys were becoming ruder.

> *'Instead of just ringing a call bell to attract the attention of the nurses, there seems to be an awful lot of finger snapping and calling out. Are they copying medical shows they have seen on television or are we becoming a rude, demanding society? I find it demeaning that I should be called this way. I am not a slave. I certainly am employed to help my patients but think that I deserve more than just a snapping of fingers. I have a name – clearly shown on my badge – and even 'nurse' is better than 'hey you.''*

There is very little literature about why the public are so rude but nurses themselves had several suggestions as to why this was so. The first is a belief that people are simply ruder today than in the past. This is collaborated by the results of Marketing Focus, a marketing research group (McNamara, 2002) which surveyed two thousand Australians and concluded that sixty percent of those interviewed were concerned about the use of bad and foul language and poor behaviour in today's society. A second suggestion was that the use of bad behaviour and language is so common today that people have become desensitized to it. What may have been considered language or behaviour in bad taste previously is often just accepted today.

Marcia, a nurse of over 20 years, worked for a nursing agency in various hospitals and clinics around the Perth metropolitan area. Her concern and frustration was with patients who expected instant service.

> *'I sometimes have 8 patients, a mixture of surgical and medical, some needing minimal nursing intervention, others requiring seemingly hours of care. What upsets me is when patients say 'If I was a private patient, I wouldn't have to wait so long'. Can't they see*

I am busy? Do they think they are so important that everything has to stop for them? I am only one person. I try to reassure them that their financial status is of no concern to me and my nursing skills and allotment does not depend on whether they are public or private patients. Are they selfish, or do they just expect too much from nurses, or from me? I find it offensive that they would think that money or status would affect the care I give to them.'

Peta also was concerned that patients just expected to get out of bed and be discharged immediately without observations being taken, discharge criteria concerning eating and drinking being met, and just time allowed to complete necessary paper work. Many did not seem to understand the necessity for these criteria and the fact that nurses were bound to them by hospital or clinic protocol.

Another issue of covert violence experienced by nurses may be the result of cultural differences between a patient and a nurse.

4.3.4. *Cultural differences*

Keely, a nurse of fifteen years' experience, reported a situation where a patient dropped his clothes on the floor instead of placing them in the locker provided. When questioned as to why he did this, he stated that '*In my country, that's women's work'.* Keely understood the episode was one that highlighted cultural differences, but felt her job had been reduced to that of a servant, despite her education, experience and skills. *'I don't pick up my husband's dirty underwear, why should I pick up anyone else's?'*

Nursing people from other cultures is a challenge all its own. Galanti (2008, p6) concedes that most people do not 'deliberately try to irritate staff, but simply behave in a way that is appropriate for their culture.' This may have been the case with Keely's patient. It may have been true that tidying up is 'women's work' seen through the patient's eyes, yet the feelings of irritation remained. Luck, Jackson

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and Usher (2007) cite three specific problems that can rise when treating patients with cultural differences from the nurses or doctors. They arise initially from a perceived personalisation of comments or activities, when a staff member feels that the offending behaviour is directed especially towards them. What the nurse needs to consider in this case is the presence of any mitigating factors and the actual reasons for that patient to present at the hospital or clinic for care. The other two problems cited by Luck, Johnson and Usher (2007), are the presence of mitigating factors such lack of privacy and other environmental factors and the actual reason for the client's presentation such as pain, blood loss and actual injury.

 Although not stated, the patient in Keely's story may feel powerless about his whole admission. There is no mention as to his reasons for admission, or any insight into his family or financial situation, and nothing about his actual state of mind or feelings towards hospitals or hospital staff. Galanti, (2008), reminds her readers that immigrants have an almost inherent fear of losing their jobs, being unable to support their families, and some, especially if they are visa overstayers, may be concerned lest they be 'found' by immigration officials. These may have played a role in this patient's attitude to Keely and other nurses, certainly upsetting for the nurse, but a result, perhaps not of genuine rudeness on the patient's part, but of misplaced distress of feeling powerless in a situation over which he had no control.

A patient's attitude towards a particular nurse may also be shaped by their perceived gender stereotypes.

4.3.5. *Gender*

A further issue identified was that of gender harassment. Three respondents, male, expressed their anger and distress at being labelled 'gay' or 'odd', usually by male patients. Gary, a nurse of four years, stated:

'I am angry and tired of trying to explain to other men why I am a nurse, why I enjoy the job, and that I am not necessarily gay just because I have entered a more female-orientated occupation. It's very wearing and, depending on the mood I'm in and the work load I have at that time, can make me very short and curt with these patients.'

The other two participants expressed similar feelings of irritation, annoyance and anger depending on how the ward/unit was running on the day, the actual words and emphases of the patients and personal mental and physical health at the time. Till, (1980) and Salin, (2007) both acknowledge the lingering bias of people towards hospital staffing. There is still an apparent acceptance of there being male doctors and female nurses. Female doctors and male nurses are still somewhat discriminated against, at least verbally if not practically.

4.3.6. *Discussion*

It is the researcher's assertion that covert violence, patient-to-nurse, is a reaction to the power inequality that a patient feels towards the health system, the staff they encounter, and/or their whole experience of being a patient. Power, by definition is '…control, influence, ascendency…person or thing having authority or influence…' (Turner, 1987, p 533). From the stories obtained, it would appear that patients either believe they have 'consumer power' or they feel 'powerless', so react by being unpleasant or rude to staff, or are unrealistic in their expectations of the health system itself. This powerlessness may be a result of their fear of the procedures they are listed to undergo, or from the fact that they are not fully aware of what is to happen to them, or because they have genuine disabilities such as mental, hearing, language or visual difficulties.

Other factors which could trigger covert violence are the use by patients and visitors of alcohol or other substances, psychiatric and

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confused conditions, particularly after having been administered pre-anaesthetic drugs, or analgesia or anaesthetics, general and genuine misunderstandings, cultural differences, and ignorance by the public as to how theatre lists, admissions and wards are administered. There may also be concerns by the public as to their financial issues such as how much, if anything, a procedure or hospital stay will cost, how long the stay will be, household concerns, especially if the wage-earner is the patient and needs to be hospitalised or off work for an extended period of time and has a lack of knowledge about how a procedure or operation may affect his/her working ability after discharge (Appleberg, 1998).

There may be people admitted to a hospital who are used to being in a position of power and who use covert violence as a way to assert their power over other people. This may be a common cause of domestic and occupational violence. This 'power' position may carry over into the person's response to hospital procedures and schedules.

There may also be environmental factors which contribute to a patient's distress, such as overcrowding or lack of perceived privacy, either within a ward or unit, or with his or her personal medical files which may be left on a desk, etc, for another person to see. Long waiting times stress patients and their families, as do delayed or cancelled procedures. It is also possible that, during the time of a particular admission, there may be a clash of personalities between patient and nurse. There need not be any apparent reason.

In the stories presented, some of these issues arose. Keely (research report 4.2.4.) was made aware of cultural differences and expectations that did not correspond with her own perceptions of what nurses should be expected to do. Both Patricia (4.2.1) and Peta (4.2.1) were confronted with patients angry at being made to wait for procedures, and Ming (4.2.3) was the victim of generally unacceptable behaviour and language of his patients.

None of these issues in themselves appear to be of major importance, but a compounding of them often leads to discontent and distress on behalf of the nurses involved, and a feeling of powerlessness and frustration as to how to deal with them.

4.4. Intra-staff issues

Forty nine responses were included in this category. These incidences were attributed to bullying (30), unfair or unrealistic workloads (10), bias against agency staff (3) or those who did not want to continue after a post-graduate rotation time (6).

4.4.1. *Criticism in front of others*

Thirty episodes of bullying reported were all concerning the criticism of staff in front of patients or other staff. These included being corrected by senior staff in front of patients, doctors or relatives of patients, the criticism of a staff member taking place amongst other staff at the table in the staff dining room and the expectation that staff would *'automatically'* be available to work overtime or extra shifts at short notice. If staff stated they were unavailable they were deemed to be rebels or non-party players, letting down the 'team' or ward. All of the complainants were offended and humiliated and each reported that none of the precipitating events were life-threatening or particularly crucial to the running of the unit or ward, and could – indeed should – have occurred in a side room out of the hearing of others.

4.4.2. *Ostracism*

During their post-graduate year nurses are rotated around various specialties such as mental health, maternity, geriatrics, medical, surgical, and theatre nursing. The idea, no doubt, is to widen their

experience in Nursing and thereby enable them to decide on any specific area they might like to pursue on a more permanent basis once their graduate programme is completed. Six of the research study respondents reported biased or unfair treatment against nurses who agree to spend their time in these specialties as part of their course but had no intention of staying in that specialty.

Two new graduates were treated as 'lepers' when they opined that although Theatre was interesting, neither saw themselves staying in that specialty. They were subsequently 'relegated' to stocking shelves or running errands. One reported that she felt '*discarded'*.

Discrimination because of lack of lasting interest in a unit was identified by Chris. She was a post-graduate student placed on a mental health ward and was determined to work hard but found that really she did not enjoy mental health nursing. She was asked by a senior nurse how she liked the ward and truthfully answered that, although she was happy being there, she would like to try other areas of nursing before finally making a decision where to work.

> *'From then on I felt that I was discriminated against …not included in ward meetings and all but ostracised at meal and tea breaks. Those of my year who did mental health and wanted to stay got extra attention and were somewhat feted by the coordinator.*

Another nurse (Sandra) reported a similar experience whilst working on a Mental Health ward. She was enjoying the experience but had decided not to continue in that field. The Nurse Manager offered her full-time work but when she declined the research respondent spent the last two weeks of the rotation filing or organising patients' external appointments. She stated she felt '*redundant*'.

Ostracism was also recognised by Win and was 'blamed' for simply being new to the ward. She was employed at a rural nursing post and had been nursing for 20 years. There were five nurses who rotate shifts at the nursing post and although she has been there for

ten years, Win feels she is being ostracised. *'There is a definite clique and I'm not part of it.'* Messages from doctors and patients' relatives are not passed on so she cannot do her job properly. Her concerns have been met with a mixture of derision and laughter*. 'I am at the stage when just thinking about going to work makes me cry but unfortunately there is no other place to work in town.'* And she is worried that if she did apply for another job, she would not be given a good report.

4.4.3. *Work loads*

A second problem identified was one of covert violence in relation to work loads. Kylie was a newly registered nurse on a surgical ward in a suburban hospital and reported an occasion when she was rostered from 10am-6pm. She was originally given five post-operative patients for whom she needed to do regular observations. A staff member went off duty at 12.30p.m. leaving Kylie with two other patients. The other two patients were delegated to a casual nurse, but it was found out later that this nurse was not due to start work for another hour. When this staff member arrived she reported the shortfall of care and Kylie was reprimanded in the middle of the ward by her coordinator for not taking care of the two patients. *'This made me feel guilty and horrified at the neglect of care that occurred apparently on my behalf….I was also devastated that an incident report had been filed citing me as responsible.'* As well as this she had not had a lunch break. Kylie felt she had been '*abused*' by her senior staff and, after a similar episode several weeks later, she asked to be transferred to another ward. There was no support for her as a new graduate and she believes that the coordinator blamed her for the inadequate staffing on the ward rather than the coordinator herself taking some responsibility.

'Excessive and continuously heavy workloads, in general, have been identified as being a cause of stress amongst nurses. Jan's story is one of excessive workloads.

'…Often there is only two nurses for twelve post-operative patients, and with quarter hourly observations this is not enough, especially when a crisis occurs. By the end of the shift both nurses are so tired and worn out that they become aggressive with each other and otherwise good working relationships are frayed. The phone rings constantly and, as there is no ward clerk, one of us has to answer it and this takes us away from our work. Each time I complain to administration, I am told that there is no other staff member or agency staff to compensate. I feel this is not an adequate excuse. Surely there is a limit to how much a person should be responsible for. Often we don't have tea breaks and lunch breaks are held on the ward, so are ineffective. Staff are just simply exhausted. Where do we stand if we make a mistake or forget to do something? I have reported this to the union but so far have heard nothing back.'

4.4.4. Lack of management support

Intra-staff covert violence may not always be obvious or related specifically to nursing. What is evident with the incidences reported is the lack of management support when problems arise and are reported. These incidences may include colleagues or medical staff. For example, two nurses actually reported the same story.

Both were nurses working in a small suburban hospital – Lois for twenty years. Clare for five. Their stories involved another 'religious' staff member. Who *'follows me around preaching at me…I HATE it'.* (Lois' emphasis). Both have spoken to the nurse manager whose only reaction is to laugh, and tell Clare she was being too 'Prissy'. The problem was that the nurse involved was a personal friend of the

nurse manager who had secured this nurse's employment. Because of this friendship, the nurse manager felt unable to speak to the perpetrator about Lois' and Clare's concerns.

The 'power' here appears to be with the perpetrator and revolved around the fact that she was a friend of the nurse manager and perhaps she felt her job was secure because of it. Lois, however, expressed her feelings of powerlessness succinctly – '*I'm pissed off!!!*'

Lack of management support is also evident in details of covert violence initiated by medical staff. The issue of conflict between doctors and nurses has been continuing since Florence Nightingale landed with her nurses at the Crimea. Perhaps this is because, for many generations, doctors were seen as 'inviolable' until nurses began to study more than just bandaging, bathing techniques and invalid cookery? Now, with the transition of nursing to a university course, it seems that doctors feel somewhat threatened. Bakker, (2003) identified this concept in the pilot study undertaken, and from the data obtained for this research, the situation has changed little.

In this research there were eleven respondents who had experienced covert violence episodes from medical staff in their workplaces. Their stories reflect situations where the nurses felt that they were disparaged because of their adherence to hospital/clinic policies and the still-unresolved education and career issues that continue to plague the profession.

Sam has been working on a 'general' ward for over twelve years. Once a fortnight a local doctor came to do small 'plastics' work such as the removal of small lesions, some suturing, etc. It was Sam's task to assist him when necessary and this had been happening for over five years.

In this time the doctor had continually 'put down' nurses to his (private) patients. On one particular day he was referring to newspaper articles about nurses seeking new certification to become

nurse practitioners, saying, 'They'll be wanting my job next.' Up to this time, because he does not direct his comment to her, Sam had felt she should remain silent, but had become increasingly *'angry and frustrated'* so this day, replied that she thought the new registration was a g*ood* idea, and that few nurses would be interested in 'wanting his job'*.*

At this, in front of the patient, the doctor 'actually yelled' at her. '*How dare you speak to me like that, it's time nurses stuck to their own job and not try to be something they aren't'*. After this, the doctor went to the manager and complained about Sam and her 'attitude', citing rudeness and apparent incompatibility with him. He asked for another nurse next time and stated that he would no longer work with Sam. The nurse manager called Sam to her office and

> *'...floored me by repeating the criticism of the doctor, she told me she was disappointed at my manner and refused to listen to my side of the story'. I feel I can no longer work either on the ward, or even with the manager and so am looking for a different position in another hospital.'*

The issue here appeared to be, not only the doctor's aggression but the manager's reluctance to listen to both sides of the situation and to support Sam in some way. Felblinger, (2007) identifies the dual problems of management being desensitised to issues of covert violence and may be actually unaware that, by not challenging the doctor, or not arranging to see both the doctor and the nurse together, there is actually an element of tolerance of their behaviours and so actually perpetuate the problem rather than confront it and settle the situation. Corney, (2008) also acknowledges this problem and suggests that there is actually an element of shame involved in that a nurse may not feel confident enough to ask for help from either management or other colleagues until it becomes a major problem. Perhaps if Sam had originally notified her manager of the verbal abuse to which she believed she was subject, albeit offhandedly, then this may not have become such an event. However, to

complain about a staff member is considered poor esprit de corps, and can lead to further aggression and ostracism and is considered a sign of professional weakness.

There are some issues of power/powerlessness felt by doctors. This is evident in Toni's story. Her response to the research questions involved a surgeon and a poorly fitting/fitted forceps. During surgery a forcep was found to be inadequate and, when Toni began to apologise the surgeon shouted at her *'If you don't know what you are doing, get someone to scrub who does.'* The circulating nurse attempted to calm the situation but she, too, was shouted at. When he snatched the forceps back to fix it himself, he was heard to say *'Oh it's broken.'*

Given that he was obviously irritated at the situation, Toni was left feeling *'…humiliated and embarrassed…some fear…some shame and VERY* (her emphasis) *vulnerable…angry at the injustice of it all.'* Originally she was going to make a formal complaint but thought it would leave her *'powerless if I handed the problem over to someone else to sort out for me'* and that might 'put him on the defensive' and thereby make it more difficult to resolve the problem*.*

She did, eventually, write him a letter outlining her concerns and he has since acknowledged his behaviour and apologised. But after discussing this with her manager, Toni was told that other staff had also complained about the doctor's temper outbursts, but no-one had been prepared to commit their concerns to paper and so had been unable to take action. This Toni felt unfair because she wondered if a 'word in his ear months ago may have prevented this situation from happening or at least from escalating as it did. Toni's belief was that the manager's apparent 'powerlessness' was just a way out to prevent any bad feelings between him and the surgeon.

This story is complicated. The surgeon has to use the instruments provided by the hospital, unless he chooses to bring his own, and so has to accept that not all are in perfect condition all of the time. Also,

given costs and concerns about the running of a unit such as a theatre, often the manager is also powerless with a budget that may not be adequate to keep up with the real needs of the unit.

A similar situation was reported by Kylie. Another nurse was scrubbed and passed an instrument to the surgeon. He apparently was not happy with it and threw it over his shoulder just missing Kylie, the circulating nurse. He shouted loudly about the inadequacies of the theatre instruments and continued to growl and complain throughout the whole theatre list. When discussing this with other staff members Kylie was told to ignore him, he yelled at everyone and was of a 'Jeckyl and Hyde' disposition, and to make out an incident report was a waste of time.

In the tea room later, he was *'extremely inappropriate talking in discriminatory tones against other cultures and races whilst exclaiming the virtues of white people…he also made inappropriate comments about women in the magazines that were on the table.'*

This behaviour was meant to intimidate nurses/women and was quite unacceptable in hospitals. However, if staff do not make official complaints about this sort of behaviour then the situation will just perpetuate itself. Nurses need to work together to eradicate such bad manners and rudeness but Glass, (1997) concedes that this may not be possible because some nurses do not want to be included in protests or situations where they have to be counted in relation to other staff members' attitudes and hostilities.

Along with inadequate budgets to purchase equipment and inadequate or inappropriate material, hospital policies also can affect staff relationships. Julie, along with two other nurses was called in at 1am for an emergency Caesarean Section. The anaesthetist had put his own jumper on over his surgical garb. When asked to swap it for a hospital cardigan as was policy, he loudly complained about the hospital, its rules, and nurses who were finicky. The issue for Julie was not so much the incident itself, but the fact that it happened in

front of a fully conscious patient and her partner. *'I felt his behaviour was intimidating and totally inappropriate.'*

Later that day, when describing this to the manager, the matter was brushed off with '*Well, it was early in the morning!'* This managerial dismissal has left Julie '*angry and frustrated'.*

> *I feel I am not backed up and will be reluctant to make any such comments again to a doctor, and my standing with the manager is also damaged. I will no longer go to him with any further concerns. I feel he does not back his staff nor really even care about how they feel.'*

Along similar lines, Billie had been working on a day procedure for about ten years. She enjoys the job except on Tuesdays:

> *'…that's Dr R's afternoon. He sees people in his surgery in the morning and often actually brings them in to have small procedures such as removal of lesions, etc, in the afternoon. He has a 'list' but he adds on, and does not let us know. Also, he won't wait until we do the paper work – he says they are only small lesions and so he can do them in a couple of minutes, so don't worry about the paperwork.'*

It sounds trivial but the hospital policy demands that all admission paper work is complete before any surgery is attempted. While the doctor was pleasant enough, he just would not comply with the policy. Any complaints to management were met with the ideal that she should be assertive and demand that he wait until the paperwork is ready. Not an easy task for a busy nurse. Billie was concerned that the patient would get the impression that they are not wanted as such, and to keep having the same arguments, especially within the hearing of other patients, she felt was very unprofessional. *'He just doesn't seem to understand that every procedure must be recorded'.*

4.4.5 Summary

Covert violence directed at nurses would appear, by these stories, to be a combination of professional jealousy on behalf of the doctors (Glass, 1977), issues of hospital policies and either the reluctance or inability of management to acknowledge that such behaviour is evident and to deal with it to the satisfaction of all staff. Tomey, (2009), identified that some of these types of concerns and complaints of nurses against medical staff could be settled with more positive managerial skills and input and a willingness to discuss the situations with the complainants, rather than appearing to brush their concerns aside.

4.5. Staff characteristics

4.5.1. Personality concerns

Personal characteristics and tolerance levels also affect medical staff as well as nurses and may affect their working. Berrie's response to the research questions included an anecdote concerning Dr P, an obstetrician, who had been at the hospital at which Bernie had worked for fifteen years. *He brings in 'lots of clients. He is a known schizophrenic and is apparently 'okay when he takes his pills'.* One day he arrived to perform a caesarean and was far from well. He was aggressive and rude to Berrie who had worked with him many times before. This time Berrie became upset and flustered making conditions worse. At the end of the procedure he thanked all and told Berrie '*You're the best nurse.'* After having been offended for the previous hour she was very angry. So she took her complaint in writing to her manager.

'I gave it to her at tea time when the tea room was full of other nurses. I felt that I needed to make my protest public and stated that I could no longer work with Dr P. He was aggressive and totally rude as well as being inconsistent in both his manner

and his surgical needs. What made me really angry was that seven out of the ten other nurses backed me up, they said that they, too, would prefer not to work with him again. They had been 'putting up' with him for years not really knowing what to do about it, so kept quiet.

'I have to say that, surprisingly (and unknown to me) the hospital had had other problems with him and his work and were actually trying to have his contract cancelled. It was my letter that finally settled the matter. I am angry because this problem had been going on so long but because no-one spoke out about him, the doctor was retained. If only the staff had spoken up earlier!' Why had management accepted this behaviour up until now?'

Because she had not been aware of previous problems, Berrie had felt isolated and originally reluctant to discuss the situation with her manager.

Ten other nurses who responded to the research questions identified similar stories and concerns about working with medical staff who were schizophrenic and/or stressed with their workloads and appeared to struggle to work compatibly with nursing staff.

This was also evident in the stories involving other nurses. Stress from personal situations and family issues, along with genuine mental health issues can make Nursing on a day-to-day basis, more difficult than it would ordinarily be. Jane's story involved another nurse who was deemed '*difficult to work with'*. This the staff had been told before she ('Jerry") had actually started on the recovery ward.

'Jerry' had had a violent marriage and was hoping that going back to work would distract her. Unfortunately she was very depressed, to the point of being depressive, and this affected all the other staff. Jane notes:

'One hour with 'Jerry' makes everyone depressed themselves and it is hard to concentrate on the work one has to do without the constant moaning and criticism by Jerry of her ex-husband. We asked the unit manager if she could be rotated around the ward roster so that no one person had to work with her for long, but he said 'No. 'She had the same qualifications as you, she deserves to work.' We do understand her situation, but all the staff feel that they are carrying around her burden unnecessarily. Makes it very hard to come to work each day fresh and enthusiastic when you see her name in the same work section as yours.'

Several other respondents presented stories that involved staff members who were 'difficult to place' making the working lives of the nurses who were forced to work with them very difficult and unsettling.

Paige's story involves a staff member who was 'shuffled' from department to department because she did not appear to get on with other staff. Whilst working in one unit she wrote down staff conversations that occurred in the tea room about management issues. Paige wrote that"

'...she had everyone's name on a different page of her note book with comments they had made to each other, and she took it to the unit manager, who subsequently spoke to the staff and told them to be 'careful' of Lynette. We refused to talk to her any more and kept all our personal comments and views to a time when she wasn't present.'

Eventually she requested a transfer to another unit, and a similar thing happened there. Then she was transferred to Paige's ward.

'Again she listed everyone's comments and took note of anyone who received a personal phone call at work, all sorts of things that were really of no harm to the running of the ward, just annoying stuff that we all got angry at. No-one knew whether

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she was 'snooping' on behalf of management or simply trying to bignote herself to them. She worked on one more unit after mine, then was finally challenged by management after a large delegation of staff, representing all the units she had worked in, rallied at the Director of Nursing's office and demanded that she either be dismissed or else transferred to another campus. This is what happened. Haven't heard from her since, but the hospital is now a much friendlier place to work.'

A similar story was told by Denise. She had worked on her ward for over ten years and believed it to be a happy, stable place to work, until Ethne was transferred in from a country hospital. Ethne was quiet and hard –working but 'nosy'.

*'She wanted to know so much about each of the staff that most found it quite intrusive. Then she started "reading" in the tea room, or so we thought. Actually it seems she was listening in to conversations and repeating them to the doctors when they did their rounds, and to the ward manager when she was on the wards or when Ethne sat at the same table in the dining room...stuff she had no right repeating such as where we went the night before, and why we needed specific days' off, etc. – nobody's business. If we were a bit slow the next day, the manager would come and criticise the staff member who had gone out, and sometimes the doctors would comment, too. It got to the stage that no-one would comment to Ethne about anything but the actual nursing duties required for that day. **THEN** [the participant's emphasis] she started driving around to staff members' places to see where they lived, and commented on what she saw, e.g. nice new fence, extra cars in the driveway, etc. We all felt spooked. This continued for about three months, then, in the end, a group of us spoke to the ward manager who said we were being a bit histrionic, so we went to the Director of Nursing and threatened to go the Australian Nursing Federation if the matter wasn't dealt with properly, and seek legal help for what we considered was her stalking.*

Everyone on the ward signed a petition so that everyone was included not just those who reported the incidences. Next thing we know, she was transferred to another area of nursing. I don't know why our original complaints weren't dealt with, or whether the threat of legal action may have swayed Management's hand, but we are back to a steady, happy group and ward, but sadly, a little wary of new staff.'

A similar story to that of Denise's was also received, but the respondent did not identify her hospital, only that it was a 'smaller suburban' hospital.

Bennie's story was about a colleague who worked with her on a general ward in a country hospital. Madge was a farmer's wife who had left nursing for a number of years to raise her children and help run the family farm. Economic constraints had seen her return to nursing, but with reluctance.

'She was unhappy almost all the time, never smiled at anyone and always grumbling. Changes of roster, overtime, a few minutes late on being relieved for lunch, etc, became really major issues to the extent that the other nurses just ignored her. We all had the same problems but in the country there are no agencies or extra staff to assist, so we have to accept some inconveniences at times. Overtime was not a regular event, and, in fact, many of the nurses were glad of the extra money a longer shift would bring, and changes of rosters only occurred when a staff member was off sick for an extended period. So, although the changes could be annoying, really she was the only one who became really angry about them. Well, it got to the point that no-one really wanted to work with her. We all knew she really wanted to be back on the farm, but we couldn't do anything about it, so it became really frustrating after a while and then actually offensive to the other staff members. A couple of us spoke to the D.O.N. but, of course, it is only a small hospital and so there were limited places for Madge to

work. I have to say, some of us sighed with relief when she decided not to return to the hospital after her holidays!'

Bennie considered this anecdote an example of covert violence because the mental attitude and actions of Madge negatively affected all the other staff members who were working at the hospital. They understood that she would rather have been working on her farm, but having decided to go back to Nursing, Madge's constant grumbling was considered very wearing on the rest of the staff. If she was so unhappy about the rosters and overtime, it was Madge who should have approached the Director of Nursing to discuss the situation.

Another example of a person's negativity and its effect on other staff members was that told by 'M.J.'

'MJ' wrote that, she had encountered a staff member who had returned to nursing for financial reasons and did not really settle in. She was unhappy most of the time and made her colleagues frustrated and angry. When they offered to help her with her tasks she refused them saying that she knew what to do and could do it better than anyone 'here'.

Through the shift the situation often became more difficult with her actually demeaning staff and abusing their efforts to manage the ward, and threatening to go to the Nurse Manager about their perceived incompetence. No-one she worked with was good enough, not supportive of her situation, and reluctant to change shifts when she wanted to, until

'One day, at lunch, one of the nurses challenged her with the problem. "L" hadn't realised that her demeanour and aggressive outbursts against the hospital and conditions had really affected her colleagues and did really try hard not to negatively affect other staff with her feelings, and to her credit, she was mostly successful, but it was very stressful for a while,

and it made a difficult job even harder when she was complaining all the time.'

Along with 'difficult' staff, another issue to be raised by the research respondents was work loads. The first to be discussed is that of work loads that appear to be determined by gender – male staff being given heavier patients or a greater number of patients per shift.

4.5.2. *Gender and work loads*

Michael, a New Zealander, had been contracted by a large suburban hospital for a year. His concern was the workload he found he had each shift. *'I find that in which ever ward I work I necessarily have to look after all the heaviest patients'*. He cited one particular situation where he was assigned four heavy patients, all having had strokes. His duties were to shower, dress, feed and change all patients alone – *'I can never get another nurse to help me change the patients or assist with showering, etc.'*

Despite discussing this with the ward manager was told '…that's the way the rosters run', but on his days off he has noticed that the four patients are 'divided' up between several nurses – 'no-one ever has four'. He believes this discrepancy occurs simply because he is male and expected to be stronger. This concern, despite his having three months left on his contract, caused him to state that I am *'genuinely thinking of breaking it…I am tired and feel I am in a bind. If I make any more comments, I think I will be further disadvantaged'.*

Three other male nurses reported that their workloads were also apparently affected because they were male and expected to be physically stronger than the female nurses on their wards. One female nurse also reported this (Sheryl) and described herself as *'tall and solid'* so she believed she had charge of all the heavier patients,

and it was she who was frequently asked to roll or move a difficult or heavy patient.

4.5.3. _Summary_

These stories presented are linked to four of the categories demonstrated by the model of covert violence discussed in Chapter Two. They are issues related to workloads, gender, staff characteristics and management. The combinations result in staff feeling distressed and angry about situations over which they have little control.

A research survey by DeCola and Higgins (2010) of 2203 nurses in 11 countries found that 92% of the respondents were distressed and uneasy about their seemingly heavy workloads, concerned that they jeopardised the care and safety of both patients and staff. Of those surveyed, 42% considered that their workloads were heavier than five years ago. This was evident in the number of sick days listed, the number of nurses leaving the profession, general job dissatisfaction and frustration among the nurses who were surveyed.

The stories of Clare and Lois (research report 4.3.4.) are mirrored in a report on a Florida health facility by Harris, (2010), in which she recounted a situation where two nurses were assigned to look after seven patients in an extensive care (Australian nurses would know it as a high dependency) ward. A third nurse, a friend of the charge nurse, was always given lighter cases, for example, two patients who were being discharged. After the patients were discharged, the nurse went off to another part of the ward to sleep. Here is an example, not only of unfair workloads, but also the impact a specific friendship between staff can have on a unit or ward, and the effects on the other staff members, such as irritation, anger and a feeling of powerlessness because their complaints, etc, are not treated fairly.

Unfair physical workloads assigned because of male gender or a physically strong build amount to an issue of bullying, and Cleary, Hunt and Horsfall, (2010), identify that this form of covert violence amongst nurses may appear to be comparatively invisible, although the effects such as burnout and discouragement amongst male nurses may result in further staff shortages and heavier workloads. In this research study there were also female nurses who reported unfair physical work loads based on the perception that they were stronger than the average nurse working in their area.

The fourth category of covert violence identified by this research was that of management issues and the impact they have on ward and unit staff.

4.6. Management

4.6.1. *Introduction*

Forty anecdotes were received for this criteria. The issues concerned management expectations that nurses felt were unrealistic or inappropriate, delayed or altered rosters, the inability of nurses to give good nursing care or to attend education sessions due to staff shortages, work loads and new policies that had been introduced which caused friction between the nursing staff and the medical practitioners. The first management issue discussed is the ergonomic issue of hours of work.

4.6.2. *Hours of work*

Twenty nurses from different worksites were concerned with the amount of overtime staff were expected to work. One stated that she worked an average of 10-12 hours overtime each week. Staff at her hospital were '*bullied*' (her word) into extra hours by management with the rider that if they did not work extra hours, their colleagues

would be stressed and unable to either carry out their work adequately or have to work back late themselves. This nurse felt 'obliged' to work back as she knew the pressures under which the other ward nurses were working.

A second complaint about overtime was the sheer expectation of it. Staff in one department of a hospital were told outright that they were expected to work overtime and would probably only be given an hour's warning. One nurse felt this to be unfair as often she had no time to tell her family of the change or rearrange appointments. She believed that nursing was only *'part of my life, not my whole life'.* She also felt that the need for overtime could most often be decided earlier in the shift. In the department (Theatre) staff work until 6pm as a routine shift and it seems often that by 3pm it is known whether the operation schedule will be prolonged, but often it was not until 5.30pm that the final decision was made. When she asked about this she was told by the Theatre manager that if she had problems doing overtime, perhaps she should consider working on a different ward or unit. '*Theatre staff work overtime, that's the way it is.*' No apparent thought was given to the need to change child-care arrangements, pick up children from school, or the other planned activities that need to be considered when shift times are extended.

Along the same lines six nurses wrote of their '*despair*' (one nurse's word) with delayed or altered rosters. One department of a large city hospital often does not receive their roster for the following Monday before Friday afternoon. Australian Nursing Federation legislation confirms that weekly rosters need to be released a week in advance, a fortnightly roster two weeks in advance.   In answer to staff complaints, nurses are told that *'Rosters aren't the only part of my job – I'm too busy fulfilling administration requirements. I just don't have the time to get the rosters out early.*' A similar complaint by a nurse at a different facility was dismissed with *'How can I manage a roster two weeks early when I'm not even sure how many staff I'll have in two weeks' time?'* This uncertainty of staff numbers from shift to shift may mean that the manager feels like '*the meat in the*

sandwich' In this situation the manager may have incomplete information to complete the task to meet the expectations of all employees in their sections of the workplace. However, with the availability of nursing agency staff and casual pool staff in the bigger hospitals, there should be few occasions when there is inadequate staffing for a roster. Certainly it was acknowledged by all staff that staff shortages did indeed cause problems but it was felt that it was truly an administration problem that should not be heaped on the nurses themselves.

This attribute demonstrates that these nurses did not appreciate the cause of the lack of information, and that upper management did not realise the stress that their lack of staffing numbers approval caused the nurses in this area of work.

One nurse has recorded that she regularly goes home crying '*in frustration*' because she is tired from working extra shifts and still cannot give her patients the care she deems they need and deserve. Interestingly this also may be the case for some of the managers, themselves.

4.6.3. *Inadequate staffing*

Eight nurses indicated that this was an issue with which they were concerned. For example, Lynn is an Infection Control nurse in a city hospital. Part of her job entails giving on-site lectures to nursing staff at relevant times regarding infections and other related issues as they arise. These education sessions are recorded along with the numbers attending, as part of her Quality Activity register. The problem is that, due to insufficient staffing/increased workloads, staff are unable to take time out to attend lectures. A provided example was that there was an MRSA outbreak on one of the wards so each staff member was to attend an education session regarding the isolation nursing techniques required. However, only four out of the eighteen staff attended the five sessions offered. Nursing

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Administration was concerned about the attendance shortfall but did not align the numbers with the workload. Lack of attendance at Lynn's education sessions are counted against her position which she feels could be in jeopardy.

I am so frustrated. I am expected to do the sessions yet can't get the staff to attend. The comment from the staff is 'find more nurses and we'll attend'. Administration say it's part of my job and here I am stuck in the middle. It is getting too hard!

This is an example of management power where a hospital needs to show the relevance of its Infection Control programme by keeping statistics of those who attend talks and lectures, yet the staffing level is such that to take staff off the 'floor' for them to attend is often unrealistic and impossible. The result is that the Infection Control nurse is unhappy and frustrated, staff are unable to get the education sessions needed, and Quality Activity numbers are not met. There is a requirement under the Western Australian Safety and Health Act, (1984), section 19, that staff are to be provided with adequate training to enable them to do their work safely. Also, having good infection control is part of safe work practices for nurses, so it would seem the answer to this issue is to either hold the education sessions earlier in the day, perhaps just after lunch so that there is adequate staff to cover those attending the talks and lectures, or to deliberately roster extra staff on the days the lectures are scheduled.

For many of the nurses surveyed, the issue of time constraints and workloads were seen as a management problem, resulting in staff dissatisfaction and anger.

Angela is a registered nurse on a mixed medical/surgical ward in a regional hospital. There are thirty beds on the ward with a mixture of day patients (up to 18), longer stays of up to four days, and medical patients awaiting placement in hostels. With only two staff rostered on the ward for each shift, often with one Enrolled Nurse instead of a

second Registered Nurse, Angela has found she cannot give 'good care' to her patients.

The elderly need time, the surgical patients need close observation and with fifteen patients each, this can't be done.' Concerns, even in writing, to the Director of Nursing have been met with the suggestion that if we don't like it, we can leave and thereby make it harder for those who stay. There is nowhere else to work in this area. The result is I am angry…I am tired. Overtime and double shifts just …add to the stress and opportunity for errors. The answers are more nurses or a cutting down of surgery lists, none of which is practical. Less surgery could mean less funding and even less staff.

Management is also under pressure to work within the constraints of the facility's funding, and also to staff the hospital. Rural and regional hospitals rarely have the luxury of having nursing agency or casual pool staff available in times of staffing crises. Frustration has led to stress in both parties.

Jane's story is similar. She works on a mixed ward of 25 beds, rarely with an empty bed. The two nurses rostered do not allow for co-ordinating the ward as well as taking a patient load. It seems that no-one had complained to management, but the reality is that:

Everyone just wants to keep quiet so they blend into the background, but someone needs to speak out. For one person to coordinate the ward with doctor's rounds, etc plus collect their patients to and from Theatre, check their observations, etc, answer the phones, arrange discharges, converse with relatives, etc. It's too much. I am tired, and so exhausted that days off are quite wasted.

Again, there is the apparent seesaw between staff numbers, economics and patient throughput. And again the administrators have to take a fine line between staffing and economic constraints.

However, the physical and mental wellbeing of both staff and patients seem to be at risk.

4.6.4. *Economic constraints*

Economics and cost-cutting may also be at the base of Shirley's experience. She is a 65 year old registered nurse of over 40 years' experience. She works in a day surgery unit which opens at 0700 hrs and closes at 2100hrs each week day. Overnight, because there are no patients, the air conditioning unit is switched off, restarting again by computer setting at 0700 hrs.

In the middle of a heat wave Shirley contacted the engineering department, asking if the air conditioner could be started earlier so that the unit would be cool enough for the comfort of patients when they were first admitted, but was told the department was under instruction from the nurse manager to keep cooling hours at a minimum and temperatures at a maximum as part of a cost-cutting exercise for the unit. Feeling quite aggrieved, the nurse approached the manager (male) and complained about the temperature in the unit and about the offhandedness of the engineering representative. His answer *was:*

> *Well, all you women are hormonal, no-one could possibly keep you all cool or warm accordingly! We need to cut costs by 2% and one easy way to do it is to cut air conditioning costs. Stop complaining, I can't do anything about it!*

Again, this highlights the powerlessness of middle management.

> *I was so angry' 'that I went back to work shaking. I couldn't tell the others what he had said, I was stunned. How dare he dismiss my discomfort as 'hormonal!' The other staff were complaining as well as the patients, so were they all 'hormonal?*

After an email was sent to the Director of Nursing and she, too, dismissed Shirley's claims, by stating that she was in favour of the cost cuts and, as the ward ran at its 'bare bones', then cutting the amount of time the air conditioning was on for was the next option. Shirley kept the email and contacted the Occupational Health and Safety officer who promised to look into the situation, but not much seems to have been sorted out.

> *I am tempted to take the situation to the Australian Nurses' Federation to see if I have a case for harassment or just poor working conditions, but my long service leave is due this month and I don't want to jeopardise it.*

Cost-cutting and financial issues were also the root of Elizabeth's claims. She is an anaesthetic technician, a registered nurse of 10 years and works in a suburban hospital. She reports that she is concerned with the state of equipment she is forced to use from day to day.

A case in point is the actual anaesthetic machine. It is fairly new – about two years old – and apparently just out of warranty. Twice in the previous month it had failed with the result that patients had to be 'bagged' by both the anaesthetist and her. Each time, despite Elizabeth having suggested the company representative come out to the hospital to check on the machines, she had been told to mind her own business and the hospital's engineering staff can cope with the machines.

> *I believe that it has come to the point that patients' lives are being put at risk in an effort to save money. I am so frightened to be in the theatre when the anaesthetic machines are in action, that I am seriously looking for a new job. I have also decided to take leave and have applied this very week. I don't want to be around when an incident occurs – either as a staff member within the theatre or one even in the hospital.*

Four other nurses wrote of economic constraints and how they affected their work loads and outputs.

4.6.5 <u>Discussion</u>

The management of a health care facility is intrinsically linked to the economics of running such an institution. Nyberg, (1990) identified this and attributed it as a cause of apparent covert violence directed towards nurses from a managerial perspective. There are difficulties in trying to run a caring environment in the financial and political constraints of modern day. The administrators have a moral commitment to their staff to provide safe and productive workplaces, but are often powerless against the budgets and limitations set by governments, or by the Board of Management in private hospitals and clinics and the health care system as a whole. Because of this dichotomy, neither side appears to win. The nurses are discouraged and aligned against management and the administrators, and management and administrators are equally distressed and discouraged because they have to account to political and Health Department guidelines and expectations, and those of the Board of Management in the private sector whose members need to return a profit to their shareholders or owners. The result is further conflict and uncertainty.

4.7. Characteristics and causes of covert violence experienced

4.7.1. Introduction

The first question for this research was to identify Western Australian nurses' experiences of covert violence. The second question was to establish the causes of covert violence experienced by nurses in Western Australian health centres. From fifty responses four themes were identified and have been discussed. They were client characteristics and care, intra-staff issues, staff

characteristics and management issues. From the data collected each of these four identified themes has had a detrimental effect on nursing staff, their work, their future employment prospects and their individual and corporate morale. The following table summarises the findings from the participants' stories.

Table 3 Characteristics and causes of covert violence

CHARACTERISTIC	EXAMPLE REPORT SECTION	CAUSE
Verbal abuse	**Swearing** 4.2.1 _____ 4.2.1. _____ 4.2.2. _____ 4.2.3. _____ 4.2.6.	Waiting too long for treatment._____ Health issues of patients_____ Unrealistic expectations of treatment_____ Society acceptance of language_____ Perceived lack of power of patients
Personal tensions	**Difficulty in working with some staff** 4.4.1. _____ **Personality clashes** 4.5.3._____ **Walking out of facility** 4.4.2_____ **General complaints** 4.2.6._____ **General anxiety** 4.1.1._____ **Depressiveness of nursing staff** 4.4.1._____ **Personality clashes** 4.5.3.	Health issues, aggression and mood swings._____ Mental state of staff members._____ Extended waiting times _____ Lack of privacy Marital issues._____ Employment issues _____ Attitude to work, economic worries, marital problems.____ Personality differences
Personal slights	**General rudeness**, clicking fingers, calling out 4.2.3. _____ **Personalised complaints** 4.2.4.	Anxiety over treatment, Society acceptance, Unwillingness to wait for attention._____ Staff under workplace stress

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Social isolation	**Ostracism** by being given menial tasks and being kept out of conferences 4.3.2. _____ **Ignored as 'new staff'** 4.3.2	Non-acceptance by other staff that nurses have preferences for specific working areas._____ Discrimination against junior staff
Mental Issues	**Anger, aggression, non-compliance to specific orders given by nursing and medical staff** 4.2.6.	Untreated or unrecognised mental illness. Drug and alcohol intake of patients and staff.
Occupational fatigue	**General tiredness** 4.4.3._____ 4.5.2. _____ 4.5.2. _____ 4.5.3. _____ **Excessive workloads** 4.5.3	Excessive workloads Unfair workloads___ Expectation of overtime. _____ Alteration or lateness of posting rosters.____ Time constraints resulting in non-optimal care for patients._____ Increased patient throughput
Gender harassment	**Male nurse being labelled 'gay'** 4.2.5 _____ **Unfair workloads** – males nurses or bigger female nurses being given heavier patients 4.4.2_____ Being given tasks above skill level 4.5.3	Rudeness of patients, stereotype that nurses are female._____ Expecting male nurses or bigger female nurses to be stronger than females _____ More patients being given to male nurses
Public criticism	**Criticism in front of patients or other staff** 4.3.1._____ **Intimidation/bullying of nurses by medical staff** 4.3.4.	General rudeness, 'One upmanship _____ Stereotypical acceptance that nurses are 'inferior ' to doctors

Inadequate/inefficient entitlements to workplace training	**Unfair educational opportunities** 4.5.3.	Poor managerial skills, poor rostering/ staff allocation.
Stalking	'**Nosiness**'**/ spying on staff** 4.4.1.	Mental state of perpetrator jealousy.
Lack of managerial support	**Complaints not taken seriously.** 4.3.4 4.4.1	Management not willing to take stand
	Inadequate staffing 4.5.3 _____	Poor rostering / Ignorance of <u>workloads of nurses</u>
	Criticism in front of other staff 4.3.4_____	General rudeness/Poor <u>personal skills._____</u>
	Non-support of staff against complaints 4.3.4_____	Poor managerial skills _____
	Non-consultation with staff about new policies 4.3.4	Not willing to accept others' opinions
Environment/ ergonomic principles not met	**Air conditioning not turned on when required for effective temperature control** 4.5.4_____	Campus economic constraints, seeming non-concern for comfort of patients or staff. _____
	Overcrowding/lack of privacy 4.2.6_____	Economic and architectural <u>constraints._____</u>
	4.2.6 _____	Increased patient <u>throughput._____</u>
	4.2.6	Insensitivity to patients' needs.
Staffing problems	**Inadequate staffing** 4.5.3_____	Poor rostering _____
	4.5.3 _____	Increased patient <u>throughput._____</u>
	4.5.3	Management insensitivity to staff <u>workloads._____</u>
	4.5.3_____	<u>Economic constraints</u>
	Personality clashes 4.4.1_____	Mental state of staff <u>members._____</u>
	Work overload 4.4.1	Excessive or heavy workloads

Inadequate equipment for work tasks	**Old or inadequate instruments** 4.3.4_____ 4.3.4. _____ **Equipment not services regularly** 4.5.4_____ 4.5.4.	Economic constraints _____ Insensitivity to surgeons' wishes or surgical needs._____ Economic constraints _____ Poor service records
Demeaning of staff	**Language difficulties** 4.2.2 4.2.4	Migrants' inability or lack of time to conform or accept local customs. Non-understanding of nursing staff as to difficulties experienced by immigrant patients
Inadequate information	**Uncertainty as to what information patients should give to staff** 4.2.2._____ 4.2.2. _____ **Inadequate preparation of patients** 4.2.2._____ 4.2.2.	Patients' own inadequate education about their illnesses or prospective procedures._____ Poor or inadequate information given to patients at pre-admission/outdated information in booklets._____ Non-compliance of preparation information _____ Language difficulties Poor understanding of procedure/s.

Nurse Advocate (1998a, p1) cites six types of covert violence (see research section 1.5). The first was bullying, intimidation and belittling and these were identified in this research. These actions were perpetrated by all four groups of people – patients, staff, medical staff and management.

The second was unwanted physical contact. This was not identified in this research, but may still be an issue in some workplaces.

The third type of covert violence was sexual harassment. This was evident especially against male nurses who were perceived as 'gay' or 'out of place' in a female-dominated occupation. One male nurse also documented that he was disadvantaged in having a heavier workload simply because he was male and therefore supposedly stronger.

Fourthly, elitist behaviour was listed. This, too, was identified in this research with nurses citing that they had been ostracised, especially after they had admitted to not wanting to continue in a particular area of work once their original rotation had finished, by being given menial tasks, being kept out of ward meetings, and simply by being ignored because they were 'new' staff.

Example five was swearing and verbal abuse. This was also evident in the stories examined and may be a result of societies seeming acceptance of such language, as portrayed in the printed and visual media.

Example six was management issues such as understaffing and disregard for staff safety and mental or physical health. These issues were also raised in this research, but the actual category has been expanded through this research to include inadequate resources such lack of staff to enable them to make use of educational opportunities, inadequate facilities such as poor or badly serviced instruments and equipment, and providing non-optimum working conditions such as lack of adequate air-conditioning. This research also identified the problem of complaints by staff members not being taken seriously or totally ignored, and the non-support of nurses against complaints made by patients or medical staff. Other issues identified were the late publication of, or alteration of rosters, and the expectation that staff would work overtime or extra shifts regardless of their own personal or family commitments.

This research has added to this original list. These additions include:

- Unrealistic expectations of both the medical service and the actual procedure to be performed, lack of privacy and perceived lack of power leaving both staff and patients frustrated and stressed;

- Personal tensions for staff were also evident in the research and these included personal financial concerns, marital issues and health issues of staff members and medical staff;

- Personal slights against nurses and general complaints which concerned the running or policies of the health care facility actually being directed to the nurse who really had no control over the issues cited. Patients were angry at their discomfort and frustration with hospital policies and systems, and nurses were angry and frustrated that they were unable to change them;

- Unrealistic expectations of staff or the health service both from patients and management staff;

- Stalking or 'spying' by other staff causing anxiety and mistrust between staff; and

- Public criticism.

4.7.2. *Summary*

Since the pilot study of 2003 there have been some positive moves on decreasing covert violence in the health services of Western Australia. Originally the target group of perpetrators were visitors and their relatives. Posters were produced and displayed stating that verbal violence against staff was unacceptable and anyone who became aggressive would be asked to leave the facility.   This

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appears to have worked, at least marginally, and with media coverage of government and Health Department cutbacks and limitations, it would appear from this research that patient-to-nurse violence is becoming less of a concern to staff, although it is still evident and causes problems from time to time.

What has risen, though, is unreasonable intra-staff violence. This may be a result of long and changing work hours and workloads, gender biases and even personal issues. These need to be addressed immediately so as not to escalate as causes of violence among nurses. The greatest number of complaints of covert violence, from the data collected, involved staff-staff covert violence. It has been reported that the managers were reluctant to challenge staff bullies, sometimes not even acknowledging the situations' effects on other staff.

The general finding is that, despite the numbers of papers, books and government policies and other publications on the topic, covert violence continues to be a major issue for nurses, causing undue stress to already work-weary staff.

4.8. Definition of covert violence

From the combination of published literature and the information gathered from this research study, the definition of covert violence needs to be expanded. It is not just concerned with bullying or intra-staff violence, but incorporates other personal and managerial issues and neither does it need to be 'repeated' to be offensive nor does it need to be physically harmful.

Given these tenets, the researcher contends that, based on the findings of this research study, a definition of covert violence is:

Covert violence is any act or word that has a negative impact on another's self-esteem, quality of life or ability to perform their allotted tasks.

4.9. Causes of covert violence

From the data received from participants, the causes of covert violence are as varied as its characteristics and were not necessarily consistent with the original model as shown in Figure 1, research section 2.10.

So from the stories cited a revised model of the causes of covert violence towards nurses in Western Australia has been developed. In the original model there were three specific factors that were included as a result of a comprehensive review of published literature, but from the data collected for this research are no longer relevant. They include nursing career structure, personal safety, innovation and best practice.

Nursing career structure. The reason that the Western Australian nurses did not identify the nursing career structure as a cause of covert violence may be because the career structure has been in place for over twenty years and those adversely affected by it have either accepted the changes in the system or have left their original position, or have resigned.

Personal safety. There is lack of information from the research respondents in this category, perhaps because it may be seen as more related to physical violence rather than covert violence. Once the covert violence perpetrator physically threatens a staff member, the incident immediately becomes an overt violence episode and is treated differently.

Innovation and best practice. The initial introduction of these protocols met with some disquiet because not all nurses were asked for their input. However, Best Practice manuals are being constantly upgraded and improved. All staff members are now encouraged to submit suggestions as to how each protocol can be enhanced, improved and made more relevant to the current running of the hospital or health centre. Best Practice, like Occupational Safety and

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Health is now seen as everyone's concern, not just those elected to a committee.

The revised model shows in diagrammatical form how each of the themes identified from pattern matching of the respondents' data are interrelated and may result in poor or unsafe patient care, stress injuries and illnesses and lack of teamwork and loyalty amongst staff. These, in turn, cause discontent and further anxiety to staff with the consequence that staff either leave a particular health service for another, or leave the profession entirely.

4.10. Revised model of causes of covert violence in nursing

Outcomes
- Unsafe client care
- Nurses suffer work related injuries
- Nurses suffer stress related illness
- Lack of trust and staff numbers
- Lack of teamwork and loyalty among staff members
- Nurses leave the health service
- Nurses leave the profession

Covert Violence
(Power/Powerlessness)

Client characteristics and care
- Treatment schedules
- Waiting times
- Inadequate information given to clients
- Society expectations
- Cultural influences

Intra-staff issues
- Criticism in front of others
- Ostracism
- Work loads
- Lack of managerial support

Staff characteristics
- Personalities
- Gender
- Perceived physical abilities

Management
- Hours of work
- Economic constraints
- Inadequate staffing
- Roster changes

Figure 2: Revised model of causes of covert violence.

Figure 2 is based on the information from research participants that is included in the following table.

Table 4: Causes of Covert Violence in Nursing

Power/Powerlessness	Response Numbers	%	Supporting published literature. Authors & publication years.
Client Characteristics			
Treatment Schedules	10/20	50%	Henderson (2003). Flynn & McKeon (2009).
Waiting Times	4/20	20%	Tragno et al. (2007). Prior (2008).
Inadequate Information	2/20	10%	Uzon (2003). Roy (2007). Johnson et al. (2009).
Society Expectations	3/20	15%	Kulwicki (2000). Alexis et al. (2007).
Cultural Influences	1/20	5%	Madden (1985). Gilmore-Hal (2001). Galanti (2008).
Intra-staff Issues			
Public Criticism	30/49	62%	Branch et al. (2007).
Ostracism	5/49	10%	Skillings (1992).
Work Loads	2/49	4%	Till (1980). Allen & Castleman (1995).
Lack of Managerial Support	12/49	24%	Skillings (1992). Lewis et al. (2007). Wang (2008).
Staff Characteristics			
Personalities	6/10	60%	Leap (1997). Hockley (2000). Murphy (2007).
Gender & perceived physical abilities	4/10	40%	Purchase (2004). Simons (2008) Tomey (2009).
Management			
Hours of Work	20/40	50%	Taylor & Barling (2004).
Inadequate Staffing	8/40	20%	Gilmore-Hal (2001). Zuzelo (2007).
Roster Changes	6/40	15%	Nyberg (1990).
Economic Constraints	6/40	15%	Moore & Comer (2005). Roche et al. (2009).

The revised model of causes of covert violence, as elicited from nurses' stories, has been designed to incorporate both the causes and the results of covert violence making each theme interrelated. Management issues such as the perceived requirement to work extended hours, economic constraints on individual wards and units as well as the health service as a whole and inadequate staffing due either to financial constraints or to poor allocation of staff or the roster system can leave staff (including managers) feeling vulnerable to covert violence because they are powerless to change the situation.

Staff characteristics such as individual personality traits and gender issues may also result in feelings of anger and powerlessness resulting in forms of covert violence, some deliberate, but perhaps some that are coincidental.

The criticism of staff in front of others, ostracism and perceived lack of management support can and does lead to frustration, anger and can result in forms of covert violence that would not otherwise be apparent.

Frustration by patients and their relatives at delays in treatment schedules and long waiting times was evident in the research stories obtained. There were also cultural differences such as the practice of mixed sex wards, being examined or seen by a doctor or nurse of a different sex, as well as personal issues such as private information being dispersed amongst staff, perceived lack of privacy and concerns about medical findings and ongoing treatment. These issues can leave a patient feeling powerless against a 'big' hospital or 'government instrumentality' and aggression may result.

All these issues, although valid, may leave a nurse feeling powerless herself – against the patients and their complaints, against other nurses with whom they have to work, and also against the department or health service in general. They become 'restless' (Roche, et. al., 2009), feel they can no longer give good patient care and are subject to an increased propensity to work place illnesses

and injuries. Moore (2005) estimated that over 600 nurses in Western Australia were receiving compensation for workplace injuries and work-related ill-health. Giga, et al., (2007), concluded that over 200,000 nurses leave the profession each year in the United Kingdom because of covert violence issues.

The model developed from the findings of this research has identified that all forms of covert violence could be derived from the concept of power versus powerlessness be the perpetrators patients, doctors, other staff members and management staff. Each brings to the workplace feelings of control, personal ease, and therefore a form of power, and also of dis-ease, which is a feeling of powerlessness.

4.11. Other identified issues

4.11.1. *Introduction*

The questionnaire offered to participants was composed of six specific questions. The first two have been discussed in this chapter. The other questions were:

- How were these episodes [of covert violence] dealt with?

- Did you report these experiences? To whom?

- What support have you received from management/senior staff?

- What ideas do you have that may reduce the incidences of covert violence in your workplace?

The answers to each of these have shown that covert violence is still not recognised as the serious work issue that it is.

4.11.2. *Episode recognition*

Of the fifty (50) participants, forty five (45) stated that very little, if anything, was done about the covert violence they experienced. Management/senior staff were reluctant to confront the perpetrators, either because they did not know how to, or were friends with the perpetrator. Five (5) respondents stated that their issue was settled to their satisfaction.

4.11.3. *Reporting of incidences*

Forty (40) respondents reported their issue of covert violence to a senior nurse but only twenty (20) of these issues were taken further to management staff. Ten (10) spoke directly to their manager or Director of Nursing.

4.11.4. *Management support*

Of the fifty respondents, forty five (45) reported that they had none or very little support from management. Most of these (40) either felt they had been 'brushed off' or ignored or told to 'just get on with your work'. Five (5) reported excellent care and concern from their managers, two (2) being offered counselling, two (2) were sensitively offered another shift with different staff and one (1) was responsible for a staff member's transfer to another department

4.11.5. *Suggestions for change*

All the respondents suggested that a culture of care and support for each other would be the most effective way to reduce covert violence in the workplace. The second was that management should take complaints about covert violence seriously, that no matter how trivial a situation may appear, it can have a detrimental effect on the staff

member, other staff working in the department or unit and other patients. However there was recognition that, on any given day, a particular episode of perceived covert violence may not actually have a negative effect on the staff member, and they believed that it may be this idea that one nurse's irritation or offence may not have the same effect on another that may lead management and senior staff's to either ignore the issue or treat it with some reserve. A third suggestion was that there be a team of support staff in each department so that harassed or concerned staff can voice these concerns in a non-critical environment. Maybe then these issues can be settled before they need to be taken to either more senior or management staff.

4.12. Summary

The stories, in the words of the nurses themselves, tell of worksites that, because of issues of covert violence, are places of frustration, discontent, anger, depression and danger to staff. The nurses surveyed had great insight into why such incidences occurred, further enhancing the information from published literature that developed the model of covert violence discussed in Chapter two.

The nurses understood that there were power/powerlessness issues among patients, medical staff, nursing colleagues and at a managerial and administrative level. While accepting this, they still maintained that because of these power struggles their work, health and future nursing goals were compromised resulting, often, in further covert violence episodes.

These samples of incidences of covert violence experienced by Registered Nurses in Western Australia have authenticated the research study by Bakker (2003) and highlight the fact that, although some attempts have been made since then to lessen the incidence and impact of covert violence on nurses, it has not actually changed the situation considerably.

The next chapter is a discussion about the experiences of the nurses who contributed to the data for this research. It looks specifically at the phenomena of power and powerlessness as demonstrated in the stories.

5. POWER AND POWERLESSNESS

5.1. Introduction

Cowie, et al., (2002) concludes that workplace bullying (a form of covert violence) may involve the use of coercive power to influence another's behaviour by means of punishment for adverse behaviour such as verbal reprimands or allocation of undesirable work duties. This goes unreported as victims often lack the self esteem to report it as they believe themselves to be powerless over the perpetrator. Hansen et al., (2006) agrees that it is this disparity between the perpetrator and the victim that prevents the reporting incidences of covert violence. The perpetrator believes they have the power to undertake this behaviour due to their status or is somehow stronger than the victim who is left feeling inadequate, intimidated and powerless.

Lowe's contention that all bullying is generally an abuse of power is equally applicable to all forms of covert violent behaviour. She states that the bully

> may hold power because he or she is a line manager, belongs to a powerful, dominant or majority group, is older, longer-serving, a larger size, or more confident. The victim is selected as someone who can be controlled because he or she has ...less power than the bully...be lower in the hierarchy, be younger, smaller, quiet, shy, in the minority (...gender, age group, social background), short-term or casual employee, ...or someone who deserves to be bullied, because he or she works better or harder than the rest of the team...or does not conform to the bully's values (he or she is gay or is thought to be gay. (2011, p53).

Following the collation of questionnaires from the fifty nurses who provided stories of their experiences of covert violence for this study, statements were extracted that specifically pertained to incidences of covert violence, and these were compared to the stories of the forty nurses in the Pilot Study. The numbers of incidences of abuse

identified from research participants and the perpetrator of the abuse are documented in Table 4.

Table 5. Comparison of perpetrators of covert violence

Perpetrator	2003		2010	
Patients	23/40	57.5%	20/50	40% ↓
Relatives	10/40	25%	3/50	6% ↓
Doctors	16/40	40%	7/50	14%↓
Nurses	12/40	30%	30/50	60%↑
Management	Not identified	0%	40/50	80%↑

In the Pilot Study the category of 'Management' was not individually identified. However, in 2010 nurses perceived that intra-staff issues were the most common cause of covert violence and that management issues were the second most reported incidences. From published literature, this seems to be an international phenomenon, the reporting of which may be on the increase. A Canadian study in 2003 of 181 nurses found that 59.6% experienced some form of covert violence inflicted by a superior (not a colleague), (Canadian Nurse, 2009). An American study in the same year reported that, from data received from 1000 respondents, 71% stated that they were bullied by staff who outranked the victims and they felt that team and management leaders abused their positions (Namie, 2003). A 1999 study of 311 registered nurses in New South Wales found that 50% of staff had been bullied, 38% of the time by managers (Birman, 1999).

A more recent study from Cape Town of nurses, working in eight public hospitals who responded to a questionnaire concluded that 'Professional nurses and senior nurse managers were identified as the main category of nurses that frequently resort to mistreating of

the nurse'. (Khalil, 2009, p210). Two American studies also report this trend. Vessey, DeMarco, et al., (2009) obtained information from 303 Registered Nurses across the United States of America. 70% reported some form of covert violence, and 55% of these incidences were perpetrated by senior nurses, charge nurses and nurse managers. Another study, of nurses of the Washington State Emergency Nurses Association concluded that of the 249 who provided information, 27.3% had been bullied by their managers, directors or charge nurses (Johnson & Rea, 2009).

The research respondents' statements were categorised into patterns resulting in five main causes of covert violence. Four of these were the same causes as identified in the pilot study – abuse by patients, by relatives, by doctors and intra-staff bullying. The fifth cause concerned management issues.. The statistics were as follows:
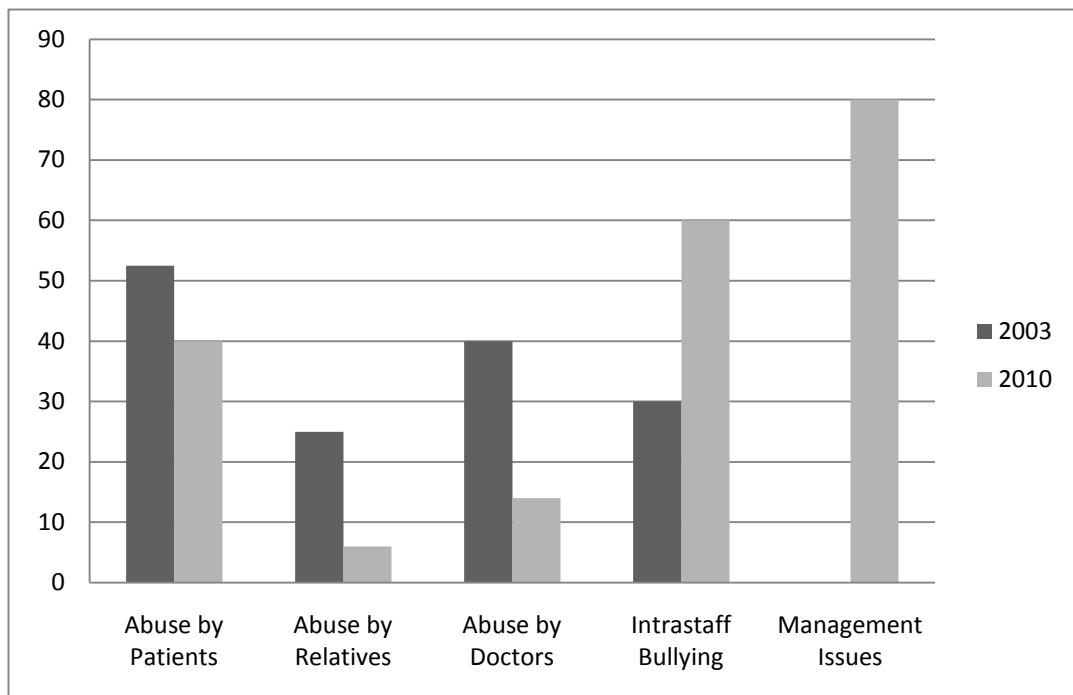
Figure 3: Comparison of causes of covert violence by percentage

Management issues for the main research study related to staff shortages resulting in poor staff education and inability of nurses to give what they felt was proper care, expectations for staff to work

overtime and poor rostering and allocation of nurses' hours of work by management. Management staff were also seen as causing some of the problems between staff such as favouritism in the hiring and placing of staff, organising lighter work loads for friends, ignoring complaints about these friends (such as Lois' and Claire's story regarding the harassment over religious ideas by a friend of the unit manager), and the perceived lack of support of nurses over concerns with other staff and medical practitioners and general working conditions such as Shirley's complaint about the ineffective air-conditioning system.

5.2. Discussion of the differences between the pilot study and the following research study

5.2.1. *Introduction*

From the Pilot Study and the main research study data analysis, it would appear that there are quite dramatic changes to the categories of perpetrators and causes in these covert violence statistics. Overall, in the 2010 study there was less abuse from patients (down 17.5%) , less from relatives (down by 19%), more intra-staff issues (up 30% from previously), less abuse from doctors (down 26%), but a new category, (that concerning Management), has emerged. There are many reasons for these changes, and these are discussed below in their various themes which include violence as patient-to-nurse, relatives-to-nurse, doctors-to-nurse, nurse-nurse (intra-staff), and those initiated at Management level.

5.2.2. *Patient-to-nurse abuse*

Actual verbal abuse of patients to nurses, when compared to the 2003 pilot study has decreased markedly.   This is due, in part, to a zero tolerance policy against workplace violence instituted for the East Metropolitan Area Health Service which included Royal Perth and Bentley Hospitals in 2004 (Australian Nursing Federation, 2004).

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This was the result of the 2003 Pilot Study into covert violence by the researcher and the results being made available to these health services. However, because the policy was not state-wide and each individual health service was responsible to institute its own procedures to manage violence on campus workplace covert violence has continued. Since 2004 most health services around the state have at least acknowledged the problem of verbal abuse by patients, and have addressed the situation by hanging posters stating that verbal abuse and violence towards staff will not be tolerated. Most health services in Western Australia have had staff training programmes instituted on how to diffuse potential violent situations, and some actually have a policy of 'refusal to treat' persistent perpetrators other than for emergencies. This change in policy appears to have also positively affected patient behaviour as well. Reports of poor behaviour by patients have decreased in this study by seventeen and a half percent from the pilot research study findings.

This may be related to the stress of waiting for care, either on a waiting list initially, or at a health service on the day of the proposed treatment. A press release dated from 2007 (Pickering) stated a case where a young lad with a broken leg was forced to wait for 12 days in hospital because there were no surgeons available to operate on him. Further, in July 2009 (Tarala) reported that, because of State Government budget cuts, there were no emergency beds available, that at least fifty percent of patients seen in the Emergency Department failed to be allocated a bed within eight hours of their admission. A follow-up column in October 2009 (Tillett and O'Leary, p5) states that 'only 49 percent of patients arriving at hospital emergency departments across the state were seen within the recommended thirty minutes, and the median waiting time for elective surgery had blown out to 30 days, three days more than in 2005'. It would seem that the health system is struggling to meet necessary standards in patient care, throughput time and post-emergency care.

A second issue may also be that of unrealistic expectations of a health service derived from television hospital dramas, where staff are seen to attend patients' needs immediately and well. In real life this is neither always possible nor reasonable.   Individual staff members may be responsible for the care of seven or more patients each per rostered shift, doctors may not be immediately available in an emergency, and there are often changes to the waiting times for procedures and admission lists because other more urgent cases arise, or there are unforeseen problems in surgery itself delaying or preventing the otherwise smooth throughput of patients.

 A further consideration may be that staff are well aware of patients' concerns and distress at having to wait for care and so are more sympathetic to their plight and are less inclined to report incidences of covert violence that may be considered more a result of frustration of patients than genuine rudeness or bullying.   Nevertheless, from this study there has been an overall decrease in the percentage of recorded incidences of covert violence by patients to nurses.

5.2.3. *Relatives – nurse violence*

The data shows that verbal abuse by relatives to nurses has fallen from 25% of research respondents' stories in 2003 to 6% in 2010.

Although decreasing in numbers, this form of covert violence, mostly of verbal abuse is still of concern for nurses. Relatives may become angry and difficult as a result of being concerned for their relative/patient or because of situations or events that may be outside their control, such as waiting times, uncomfortable waiting rooms, stress over hospital or clinic parking, other patients or relatives nearby.   It may also be due to a heightened public awareness of patients' rights within a health service and to relatives who are becoming more willing to be patient advocates.

The researcher contends that verbal violence against nurses is a characteristic of the dichotomy of power and powerlessness.

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Patients and their relatives have certain rights (power) given to them by the health service, through their understanding of media presentations and online information, but they may feel powerless when actually a 'consumer' of the health system and when their perceived personal concerns are not met by the staff in a manner or timeframe that they had expected.   This perceived power/powerlessness can create an atmosphere of concern, fear and mistrust by the patients of the staff present and of the health system in general.

5.3.   Patient Power and powerlessness

5.3.1. *Patient (consumer) power*

The word 'patience' is defined as '…endurance of pain or of any provocation; perseverance, quiet and self-possessed waiting for something.' (Turner, 1987, p.799).   Historically this is what a health consumer was supposed to be – patient.   Hospitals, their governing bodies and medical and allied professionals made the rules as to how patients were to be treated and also how patients were to behave.   Rarely were these patients consulted.   They were to accept their treatment with grace and acquiescence.

However, by the late twentieth century this began to change. Patients were relabelled 'consumers' or 'clients' and with this new label came rights and expectations and a whole new challenge to the health system.   Concepts such as 'patient-power' and 'patient-centred care' became buzz words for a situation where people were encouraged to take an interest in, and control of, their own health problems.   Information about health issues could be accessed easily via the internet, through television programmes, in the printed media and pamphlets became available at health service outlets informing patients of their rights and probable expectations for their care.

Both nurses and doctors were initially happy with this new patient role 'It's good – it keeps us on our toes.   It means health

professionals think more about what we are telling people [but] it can mean longer consultations because you have to explain what it all means.' (Richards, 2008, p.1). A patient now has access and input into how a hospital or clinic is run, how that hospital fares in healthcare provision, information on their physicians and their care, and seemingly endless brochures about various health issues and facilities available for those who need extra information or advice. The Health Department and most private hospitals have annual and/or ongoing projects regarding patient satisfaction with their care. To this end most patients are given, either personally, or at least access to, forms with which to detail the complaints or the credits they may have with their care.

While the researcher agrees wholeheartedly that health care consumers should take an active part in their own well-being, there is a danger that they may become victims of their own knowledge base. For example, not all information that is posted on the internet or written in books and newspapers is correct, or even current. Likewise some information is posted with specific aims in view such as that of advertising a particular medication or product that may sway a reader to believe that that particular product or pill is the 'best' or offers the most effective results. Nevertheless, patients are now becoming more knowledgeable about their illnesses and are challenging the care they are receiving resulting in a much more responsible health care system. There is also the possibility that correct and persistent lobbying by patients/consumers will attract better funding for health campuses and a more efficient use of that money by the hospital boards and committees.

One of the greatest problems with this consumer power is that often the demands (seen as rights) are unrealistic in a hospital or clinic situation, particularly if there is insufficient staff available to meet what patients perceive as their rights. Patients 'demand' that they be seen first and promptly, that admission paperwork and protocols should be waived to facilitate faster processing of clients. Realistically this is not usually possible. There is a set format of

information gathering and preparation for a patient's admission, and legally (as well as sensibly) these need to be completed, yet not all prospective patients understand nor accept this.

Some of the stories included in this research may have occurred because of misplaced consumer expectations. For example, Patricia (research report 4.2.1.) related that she was concerned with the number of patients and their families who became rude and agitated about having to wait for service, that they demanded to know why they were not first on the theatre list, etc, Similarly, Ming (4.2.3.) was offended at young patients who demanded attention by clicking their fingers or calling out 'Hey you", and Keely who was unhappy about being expected to pick up a patient's clothing, all believing that these forms of behaviour and expectant result had relegated their role from nurse to slave (4.2.4.).

 Perhaps in some situations, then, the idea of consumer rights and power may actually result in having a negative effect on a patient, a staff member or even on the health service itself. What is in itself a good and recommended initiative may become an aggressive, even abusive episode with patients demanding far more than a hospital or clinic is able to give, either in staffing or in the use of resources. Those who protest about their care, or lack of, certainly have the right to leave and to write about their experiences, however, as with Peta's story (4.2.1.), this may just result in more staff becoming distressed and leaving the profession.

5.3.2. *Patient (consumer) powerlessness*

Not all patients have either the ability or desire to take control of their health issues. Not all have access to a computer, and many are handicapped because of their lack of education or language skills and these lead to feelings of powerlessness. Along with these problems may be cultural, religious or ethnic protocols and procedures that may interfere with their understanding or acceptance

of their admission or treatment procedures. Other issues may be distress from a chronic, acute, terminal or debilitating illness, poor family and social support, age of the patient, communication deficits such as language difficulties, hearing or verbal deficits, depression and general passivity. Some or all of these can make a patient more fearful or anxious about their health condition and admission. Waiting for the results of tests, x-rays and biopsies may compound on their stress and make them aggressive, non-compliant with staff, rude and abusive.

Jenny's story (research report 4.2.2.) of an elderly lady who was confused about her own health issues, the tablets she was taking and the procedure she was to undertake perhaps emphasise the problems of people who feel powerless over their condition, their admission or the prospect of returning home in pain, discomfort and confusion. This elderly lady's verbal skills were limited, she may not have been able to voice her concerns, or may not have been able to think far enough ahead to arrange family or social support on her discharge. This might have been addressed by the admitting doctor prior to admission if he had been aware of her difficulties; but in reality; she may not have discussed them with him.

5.3.3. *Patient Obligations*

5.3.3.1. *Knowledge of medications*

Given that any hospital or clinic setting may be unsettling, even frightening, patients and their families still have a part to play in the smooth running of a ward or department. This includes knowing details of their medications, for what procedure they are being admitted, and having some idea as to how long they will need to wait for that procedure or before seeing a doctor. Most hospitals and health campuses visited by the researcher have booklets which outline patients' rights and responsibilities, but these are usually placed at the bedside. They should be given to the patient when

they attend their pre-admission interviews or posted to those who have not scheduled an interview.

Knowing what medications patients are on is a vital part of the admission protocol carried out by nurses. Unfortunately it is often the first time a patient may feel threatened by the whole process of admission, and being questioned by nursing staff may compound that perceived threat. Certainly, in some hospitals, this information is gleaned beforehand in a pre-admission interview, either carried out via a phone call or on a face-to-face basis. However, with more people working it may be difficult or impossible for a pre-admission nurse to contact the prospective patient and with increased numbers of people being admitted for procedures and emergencies, actually scheduling a preadmission interview may be quite impossible.

It is often the case where, when asked for a list of medications, the patient/client will say *'Oh, I am on a blood pressure tablet. It is red, you'll know which one it is.'* Or '*I don't know the names of them, my wife/husband gives them to me.'* Or '*My doctor has a list of them, he'll know.'* It is hard for some patients to understand that it is not the nurse who should know 'which one' or what dosage is taken, or that the doctor's notes are rarely seen by the nurse, so he/she would have no idea what medications are listed. In some hospitals it is true that often it is the doctor who documents medications, but in smaller units or in some day surgery units where a doctor literally comes in and operates then leaves, this may not be the case.

Members of the public should be encouraged to keep a list of current medications in their wallets or purses for just such a situation. This could include all 'over the counter' medications that the patient takes which may not be actually prescribed by their local doctor. The details, then, would be available with less effort from either the patient or nurse.

Some people in the community are prescribed 'blister packs' of medications which are dispensed by a Pharmacist into 'blisters' with

medication divided into specific dosages and times for their dispensing. It would be of value to both patient and nursing staff if patients were encouraged to bring these 'blister packs' into hospital with them. In the blister pack each tablet is recorded, as is the actual dosage. On discharge, tablets no longer required can be excluded from the next pack blister pack or new medication included in the next blister pack according to the medical practitioner's discharge prescription for this patient.

5.3.3.2. Perceived economic disadvantage

Economics may also have an effect on a patient's perception of their health care. The very fact that some people cannot afford private health care may result in their waiting sometimes years for procedures such as carpal tunnel release, knee reconstructions or cataract surgery which may be available to privately insured patients in just days or weeks. Limited income may be a source of anger, embarrassment and even fear, aggravated by pain, disability, depression and have an impact on their attitude to staff and other patients. The Australian Institute of Criminology (2002) believes that in Australia both victims of violence and violent offenders are drawn from the most disadvantaged socioeconomic groups, and so it relates that people who are economically disadvantaged may feel powerless over a seemingly despotic and protocol-driven health service. They may feel trapped into accepting a service over which they have no control or input. This issue of economic disadvantage may have been the reason for Marcia's story of covert violence (4.2.3.). The concept of *'If I was a private patient, I wouldn't have to wait this long'* is not necessarily a slight on the health care or service, more a distress signal from one who is anxious and needs a hook on which to hang their feelings of powerlessness.

Patients from different cultures can experience a wide variety of problems simply because they are in a new country. Pasca and

Wagner (2011) conclude from their research that migrants face problems adjusting to language and other communication barriers, general understanding of how processes such as hospital admissions may work in their adopted country, issues of secure employment (especially if they experience an episode of ill health), relocation problems and personal identity problems. They may feel discriminated against simply because they are immigrants, perhaps because they are no longer able to find the equivalent work or status they held in their country of origin. These concerns may have been the catalyst to the perceived covert violence experienced by Keeley (4.2.4.).

5.3.3.3. Awareness of booked procedure

Another area of concern is where patients are not fully aware of the procedure for which they have been admitted, but also for other medical issues they may have.

When asked to confirm the details of a surgical procedure to be performed in less than an hour, a patient reported to the researcher that '*It's something to do with my arm, but George has been my doctor for years, he'll know what to do.*' This from a well-educated Australian with no apparent language problem or lack of access to information. The question about what procedure for which the patient has been admitted is very valuable to nursing and medical staff in that they can and so compare the patient's information with the theatre list to ascertain the right patient, site, position and procedure before a preparation is begun. When a patient does not know the full extent of his planned admission, then staff are bound by law to challenge the actual admission of a patient. When the details are wrong or confused or 'unknown' then the surgeon or doctor in charge is usually queried, holding up the lists or process creating stress to all involved. Again, in some hospitals, these details may be handled by the doctor, himself, but in others, it is the

nurse who collates this information. The patient, if mentally competent, should therefore be held responsible for at least knowing what ails them and for what procedure they have been admitted. This may not always be possible, of course, depending on the patient's actual mental condition, in which case, a relative or care-giver should accompany the patient to hospital, and they should be aware of why and for what procedure their 'charge' was admitted.

5.3.3.4. Realistic Expectations of Admission

Not including emergencies, patients should have already asked their doctor or preadmission nurse about the expected length of time they may have to wait for their procedure once admitted, and how long they may need to wait post-procedure before being discharged. Unfortunately, many assume they will be able to just literally walk in and be seen, to go home in an hour with no follow-up necessary. This may be due in part to some doctors telling patients that their procedure is only 'minor' and will only take a few minutes to perform. This may not take into account the time needed for the admission process, the administration and recovery from anaesthetic, and discharge protocols to which staff must adhere.

5.3.3.5. Courtesy to All

Having attained some idea as to how long the procedure or admission might take, and having been notified by a preadmission clinic as to what time to attend the hospital or clinic, it is up to the patient to arrive on time. If they are late, sometimes it is possible to rearrange theatre lists, but this is not always possible or practical. If a patient believes that they would not be able to attend at the time allocated, perhaps because of transport difficulties or family commitments, then they should discuss this with the doctor prior to admission so that he may arrange for them to be listed later, or even

cancelled and their admission rearranged for a later date. Patients expect courtesy from staff, and by complying with admission times, they in turn show courtesy to staff and the hospital system in general. If it happens that the patient cannot attend for any specific purpose this courtesy would again be extended by notifying the hospital in sufficient time to allow reallocation of patients. The researcher, over the years, has contacted many 'late' or 'non-attendees' to be told '*I thought by now you'd know I wasn't coming.*'

Most people have access to a phone and such a small simple gesture of ringing in and explaining the situation would seem to be a generous, courteous action.

5.3.3.6. Personal Education

Patients need to take, wherever possible and practical, responsibility for their own health and for the ongoing processes that they can expect from their hospitalisation. They must ask questions of their doctor until they have adequate information. If language is a problem or if there is a 'gap' in understanding, then a relative, friend or interpreter should accompany them to any preadmission procedures involving doctors or hospital staff.

5.3.3.7. Responsible Behaviour

Patients need to be more aware that nurses are not responsible for the layout or general conditions of the hospital ward/unit, the length of a surgery list, nor the actual position on a list. They should also understand that in some public hospitals there may be limited resources such as food and drinks that are provided for patients. Often they are only provided as a 'snack' to assure nursing staff that patients are able to tolerate diet and fluids in order to meet the discharge criteria (Peta's research section 4.2.3.). To become aggressive because they are not first to be seen or have to wait for

service is not acceptable. The researcher also believes that, even given the overlay of alcohol or drugs, a person should still be held responsible for their behaviour in any public or private setting, especially in a hospital.

The management of the Walsall Hospital Trust (Isle of Man) is also of the same opinion. In a media release to the local newspaper, the Trust has introduced a system of 'red cards' which are directed towards patients or visitors who are violent, aggressive, damage vital equipment and offer verbal abuse and threats to staff and other users of the health system. 'The ultimate sanction or 'Red Card' will be issued when behaviour is deemed totally unacceptable. This will include exclusion from hospital premises and withdrawal of treatment….The Trust will identify an alternative healthcare provider for the individual and in an emergency the excluded person will receive treatment to stabilize a serious medical condition.' (Browne, 2005, p6).

The idea of red-carding abusive and difficult patients has been mooted by the Alfred Hospital in Melbourne (*Western Nurse*, 2011). Like Luton and Dunstable Hospitals in the United Kingdom, it is anticipated that a red card 'would only be used for patients in non-life-threatening situations and not [for those]...with a physical or mental illness' that have caused the abusive behaviour. The Alfred wants to institute a yellow card 'warning' and then '...if they continue to misbehave they could be red-carded and escorted out.'(p13).

5.3.3.8. Adherence to Advice

Patients and their relatives or carers should take responsibility for adhering to the pre-operative demands of the surgeon. In Kandy's story (report section 4.2.2.) where a patient was admitted for surgery yet not fasted, both the patient's mother and the doctors were angry and abusive to the nurse. Although it is now customary that most hospitals have a pre-admission clinic, in this situation, the pre-

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admission nurse was unable to contact the mother and, as she did not adhere to the anaesthetist's instructions, she was angry, the anaesthetist was angry, the surgeon was angry, and the nurse seemed to be the brunt of all of them. Responsibility to adhere to instructions given (especially seeing they were actually written instructions) rest solely on the shoulders of the parent for children and on the adults of their carer for other patients.

5.3.3.9. Summary

Certainly people who are admitted to hospitals and clinics are concerned with their health and the well-being of their families whilst they are infirm, and all the problems such as language difficulties, differing customs, long waiting times and inadequate facilities identified in Chapter Two are important in the overall care of the patient, but they are not acceptable reasons for patients and their relatives to be rude or aggressive to nurses.

Patients, as far as they are able, must take some responsibility for their own health care, knowledge and behaviour, otherwise the power/powerlessness 'cycle' continues and perpetuates the issue of covert violence. It would seem that although most hospitals and clinics in Western Australia have espoused a zero tolerance policy for aggressive behaviour, rarely has this ever been challenged. A red card system similar to those of the Walsall and Alfred Hospitals may be the answer, but would be a major leap from the traditional hospital/nurse philosophy that patients' criticism and aggression are just 'part of the job'. This idea should be eradicated completely. All staff and patients have the right to work and rest in an environment free from aggression, verbal abuse and physical threats.

5.4. Medical Practitioner Power and Powerlessness

5.4.1. Doctor power

Historically, hospitals were the domain of men – both nurses and doctors. With the advent of structured nursing schools, female nurses were deemed as 'skilled servants operating in strict obedience to the physician's power' (Morrow 1986, p217). To quote Johnstone (1994, p.3) 'a nurse lacks legitimated authority…and is legally bound to obey the lawful and reasonable orders of his or her superiors – the medical practitioners…who were in a better position to decide on what is the right course of action in clinical, administrative, ethical and other matters.'   Hospital boards were mainly composed of physicians and surgeons who considered that they 'owned' the services for which they were paid reasonably well.

There are doctors today who still cling to this history of (usually) male hierarchical system with often lucrative contracts still being paid for service. This gives them supposed power in that most internal services of a hospital such as physiotherapy, pharmacy, outpatient clinics, ward admissions and theatre lists are geared to doctors' lists and availability. Without them, most hospitals would cease to function as a creditable whole, government financial backing would be in jeopardy and therefore the general health care provision of the facility would decrease. Doctors are therefore aware of their 'position' of power. Without them, there would be very limited healthcare.

Berrie's story (research report 4.4.1.) regarding a surgeon confirms this when she wrote that the doctor brings in '*lots of clients'*, and therefore, she believes, he is rarely challenged as to his '*totally rude'* and aggressive attitude to the nurses with whom he works. Not only would the hospital lose his clients if he resigned, but she also feared that staff were concerned lest they lost their jobs by reporting him.

Julie felt intimidated by a doctor who refused to comply with hospital protocols for theatre wear (4.3.4.). *He 'complained about the hospital, its rules and nurses who were finicky'.*   By refusing to confront the

issue with the doctor concerned, the theatre manager not only made the matter seem worse and Julie more '*angry and frustrated*', but may have unwittingly perpetuated the dominant male (doctor) role against that of the subservient female (nurse).

5.4.2. *Doctor powerlessness*

Given the historical roles of doctor/nurse, there is a case for doctors feeling powerless in a modern hospital/clinic situation. Nurses are being educated to university level and are being deemed 'nurse practitioners' thus taking some of the 'knowledge kudos' from the doctors themselves. To some extent, doctors are being professionally 'threatened' by these changes in nursing. Sam relates that nurses assisting a particular doctor on her ward were constantly being 'put down' in front of patients with words such as *'They'll be wanting my job next…it's time nurses stuck to their own job and not try to be something they aren't.'*

Doctors are also at the mercy of new financial deals between hospitals and the Health Department. O'Leary (2008) cites a city hospital as having a financial deficit for 2006-07 of $6.8 million. This effects doctors' contracts, the number of beds available for admissions, theatre lists and even the replacement of old, ageing and obsolete equipment, maybe even to the closure of some smaller hospitals or clinics (O'Leary 2008). This will result in a backlog of theatre cases (O'Leary, 2009), even cancellation of services altogether. O'Leary (2009) reports doctors, patients and nursing staff have complained about one large city hospital having obsolete and inadequate equipment to meet surgical, x-ray and general ward needs. O'Leary, (2009, p10) quotes Professor Geelhoed, Australian Medical Association W.A. President as saying 'You can't have everything going out of date and think that won't affect patient care…[there is a need] for funding for replacement'. With all of this, doctors are powerless against such bureaucracy. They ultimately are blamed by patients for extended waiting lists and delays in other

services such as radiology and yet are in no position to improve the situation. Toni, it would seem, was a victim of the frustration of a surgeon when she handed him an ill-fitting forcep (research report 4.3.4.). He had a theatre list to complete with them and personal restraints, and the equipment offered, although through no fault of the nurse, was of poor quality and inadequate for use.

Other issues facing doctors are long working shifts, especially for obstetricians who are bound to early morning/late night deliveries, surgeons who are on call throughout the night or weekends, hospital and clinical facilities which are rundown or non-existent and specific protocols of campuses which are not necessarily in 'favour' of doctors. Like nurses, they also suffer from stress, have marriage problems and may find their hospital contracts may be in conflict with their own private practices. All these factors result in feelings of powerlessness, unable to fix any of these problems yet held responsible if any mishaps or inconsistencies occur. A no win situation. Unable to influence the financial, staffing or equipping of a hospital or clinic, while expecting to continue to service the facility, can only lead to further frustration, general discontent and earlier retirements, thereby making the situations of staffing and financial concerns even worse.

As with patients, doctors working in health care settings need to take some responsibilities for their work, their attitudes and their behaviour.

5.4.3. *Doctors' Obligations*

Doctors are undoubtedly important in the running of a hospital or clinic, especially where surgery is carried out, and obstetrics is part of the service provided, however, they, too have responsibilities in maintaining a suitable working environment for nurses and need to make themselves aware of the Risk Control Action Plan (Appendix D).

5.4.3.1. Correct Information for Patients

A doctor's first responsibility is to the patients themselves. They should be given correct information as to the running of a ward or a theatre list. The oft spoken *'It'll only take a few minutes and then you can go home'* is not accurate or fair to either patients or staff. A procedure may indeed take only a few minutes, but time will need to be spent on procedures for admission, post-operative observations, diet and fluid intake measures, etc. This often means that a patient may be in a hospital setting for anything up to five hours, and that is assuming there are no complications either with any pre- or post-operative ventures. If patients are told this, they are more able to arrange time off work, care for any dependants they may have, and even some clue as to how much money needs to be allocated for parking, etc. Often a preadmission interview is arranged for the day prior to surgery or admission, but by then it is often too late or too difficult to change personal arrangements, so a doctor, surgeon or anaesthetist needs to be honest with a patient as to what to expect during an admission. Nurses usually take time to glean information from a doctor as to preferences for surgical equipment, drug administration, specific post-operative requirements, etc, and so a doctor is also responsible to ascertain how a ward or unit to which they will admit patients will run, and make themselves aware of standard protocol for the admission and discharging of patients specific to that hospital or clinic (see Lynne's story research report 4.5.3.).

Along with this is the actual filling in of information on a Request for Admission form which is forwarded to hospitals by the surgeon or doctor who sees a patient and needs to arrange their admission, either as an inpatient or a day case. On the request form are places to indicate whether a prospective patient has any special needs such as language difficulties, weight issues, speech, hearing or mobility problems, whether they suffer from any allergies or have had any adverse reactions to drugs in the past, and whether are self-caring or in need of a carer. This form is usually forwarded to the hospital or

clinic within three to four weeks prior to admission. If this is filled in appropriately then nursing staff have the opportunity to arrange facilities such as sufficient room for a carer to at least be seated throughout the admission, perhaps to arrange a meal for that carer, or a cot for the baby of a breast-feeding mother or to organise for special crockery, cutlery for those who cannot manage with the normal cups and plates, or even a suitable bed or trolley and bed attire to manage a large patient. These things, in themselves may not seem especially important but given that wards and units are busy, especially in the admission phase of a patient's visit, then anything that can make that phase run smoother is of importance. To tell a patient on admission that they are too large for normal gowns or pyjamas or the bed or trolley assigned to them is both embarrassing and can cause great angst for them. It also shows up the unit or ward as being underprepared. Likewise to be unprepared for a 'resident' carer is not acceptable. Indeed the researcher has found that they are a very valuable asset knowing the patient and their needs far better than the nurse, knowing how to move them, position them and feed them. Again, with a patient who is deaf or hard of hearing, they can be addressed appropriately with determined eye contact or with the aid of a writing pad and biro, or a palm card system rather than having them feeling lost and somewhat out of control of their circumstances.

The details of the Request for Admission form are crucial for the smooth running of a unit or ward. It can set the scene for problems immediate to the admission of a patient which can be seen as detrimental to both patient and staff. To take an extra couple of minutes at the initial surgery interview to fill out the forms will no doubt make a difference to how a patient sees his or her admission process. A little preplanning by the hospital staff can ensure that the admission begins at least with some dignity for both staff and patients.

Patients also need to be made aware of specific pre-or post-admission care, preferably in writing. Many people are unaware that

'fasting' includes both food and fluids. This should be made very clear to the patient. It should also be made clear that failing to adhere to this instruction may mean total cancellation of the procedure or admission.

5.4.3.2. Responsibility to Hospital or Clinic

Doctors also have obligations to the administrators of the clinic or hospital in which they work. Any perceived problems they may have with internal policies should be addressed to the Board or Committee involved, not taken out on the nurse (see Julie's story, research report 4.3.4.).

5.4.3.3. Consideration of Other Staff

Nurses are often the recipients of aggression from doctors in relation to hospital policies (see Julie's and Billie's stories in research report 4.3.4.) the implementation of which are rarely discussed at a ward level with nurses and sometimes with no prior warning to their use. This not only upsets the nurses and often the patients who hear, but also upsets the smooth running of a ward, theatre or clinic, it compromises the professional repartee between staff, and can even jeopardise future dealings with staff (see Berrie's story, 4.4.1.)

The zero tolerance policy concerning aggressive behaviour should also be extended to include doctors, perhaps resulting in exclusion from some hospitals as in Billie's story (see research report 4.3.4.) Certainly doctors are overworked, get tired and run late for appointments, but there is no reason to become aggressive with staff who are attempting to maintain a professional persona to patients and to other staff.

5.5. Nurses' Power and Powerlessness

5.5.1. *Nurse Power*

History and personal experience tells stories of when younger nurses were protected somewhat when other patients or staff abused them. The concept of disciplinary power is evident in the hierarchical system of promotion, levels of seniority and professional ethics maintained this situation. There was respect from other nurses for each position, often granted through years of service and experience. But this power base has been eroded by both patients and staff and, to a certain extent, by the individual nurses themselves.

5.5.2. *Nurses' powerlessness*

With the advent of consumer (patient) power there has been a realignment of power within the hospital/clinic situation. No longer do nurses hold the total knowledge base, patients being encouraged and empowered to seek out their own information needs via computer and other forms of media. Instead, nurses are now anxious lest patients take umbrage at their care, consider their rights have been compromised and 'report' the staff member/s.

The threat of liability was made evident by Patricia Staunton at the 1st National Rural Health Conference, held in Toowoomba, Queensland in 1991. She warned:

> Medic-legal litigations are on the increase and more and more people will question, more and more people will challenge and more and more people, as it were, take you on and if you are found wanting, then unfortunately you have to rely on your own resources to get yourself out of that...you are all in potentially vulnerable legal situations. (1991, p. 24)

The Australian Nursing Federation acknowledges the situation and offers 'the protection of professional indemnity insurance and legal benefits...with cover for professional indemnity (malpractice) up to $10,000,000, cover for public liability (negligence for injury to a third party, persons or property) up to $10,000,000 [and] 24 hour

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insurance cover for Good Samaritan Acts.' (Australian Nursing Federation, 2001, p2) In Australia, all nurses must have evidence of professional indemnity insurance which they must hold in order to register with the Nurses' Board in each state.

As a nurse in today's healthcare industry there are no longer the expected promotions due to experience and longevity in a workplace. There are limited career options, limited placement options, long hours, few opportunities to seek self-improvement and there may be a general disappointment with nursing in general. Vacant situations are likely to be filled by an 'outsider', perhaps one who has had many other appointments (once if one had worked in many places they were seen as unreliable and somewhat flighty, now if nurses stay in one place they are seen as in a rut, or unwilling to accept change or simply lacking ambition) or a friend of someone in management, perhaps even someone with limited experience but with a specific qualifications. This is the situation with Lois and Clare who were offended by a new staff member but could not protest to their manager because the abuser was a personal friend and it was the manager who had hired her in the first place (research report 4.3.4.).

Chambers (1998) combines powerlessness with oppression leaving nurses feeling lost and neglected.   This oppression is perpetrated by the hospital itself, physicians and management. Junior Nurses are rarely consulted when hospitals and clinics are revising or writing protocols and practice manuals, they are not given the opportunity to advise or assist the hospital in arranging theatre lists, equipment, rosters or staff movements. However, they are on the front line and are often take the brunt of doctors', relatives' and patients' frustrations and anxieties. To complain would be somewhat against their socialisation as a nurse, and for many, there is a fear of discipline or even dismissal.

Seiloff (2004) suggests that this oppressive environment is fostered by management to maintain the status quo and to continue to decrease the oppressed group's power. 'Nurses may feel "stuck" in

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an intolerable job because they can not make a change although opportunities for a change do exist' (p.247). Jan's story (4.3.3.) highlights the powerlessness nurses feel over their seemingly impossible workloads – *'everyone just wants to keep quiet so they blend into the background, but someone needs to speak out.'* Kylie also found herself a victim of oppression when she was criticised for neglecting her patients although she had had no opportunity to complete her tasks which was the result of lack of staff members and poor rostering (research report 4.3.3.). She felt she was given no support from her peers and was 'abused' by her seniors. The result was that she asked for, and was granted, a change of ward.

Chris also felt unsupported in her decision to not continue with working in the mental health wards when her postgraduate rotation was completed (4.3.2.). Because she was honest and admitted that the specialty was not for her as a long-term prospect, she was 'abandoned' and made feel inferior and unworthy of the other staff's interests.

Michael believed he was in a no win situation when he was given the most difficult and heaviest patients on the ward simply because he was male (research report 4.4.2.). No other staff member offered to help him, nobody offered advice and often he was last off his shift because of the complexities of care he had to give. He felt helpless in the situation but felt he could not complain because he had signed a contract with the hospital and believed that if he broke the contract that information would follow him to any future appointments. Sheryl believed she, too, was given a physically heavier workload simply because she was tall and physically strong, and, like Michael, was rarely offered any help from colleagues (4.4.2.).

Like nursing and medical staff, managers and other senior nursing staff face problems of their own in relation to feelings of power or powerlessness in the positions they hold. To minimise these problems, nurses have a set of obligations they need to fulfil in order to maintain the smooth running of the health care facility.

5.5.3. *Nurses' Obligations*

Nurses are in the 'front line' of any clinic or hospital and so have obligations to all with whom they work – patients and their relatives, the doctors, other nurses and to those representing Administration. The enormity of this responsibility seems to be somewhat exponential particularly when hospitals are faced with financial cutbacks yet pressured into longer and more complicated admissions and theatre lists. To stay focused on the tasks in hand rather than disagreements and discrepancies is a tough call. However, for a ward or unit to function efficiently this is what is needed. The Risk Control Action Plan (Appendix D) is also relevant for all nurses who work in a hospital, clinic or other health campus. The issues are discussed below.

5.5.3.1. *Provision of a safe working environment*

All staff are responsible to ensure a safe environment in which to admit and treat a patient. This means that each nurse is individually responsible for the equipment they use and for safety on the ward or unit. It should not be left to Occupational Health and Safety Representatives. Situations which should be monitored are the sturdiness of the bed or trolley, leaking taps or water on the floor of toilets and showers and suitable cups or mugs for post-operative drinks. The possibility of slipping, scalding with hot liquids or falling from a bed is real and would only add concerns to an already distressed or uncertain patient or their families. This Occupational Safety and Health (OSH) awareness also extends to the general lighting of the area and the soundness of the flooring. Dark corridors and 'lifting' carpet are hazards that can result in injury to all who use the area. Concerns over such should be notified in writing to the area manager and to the Occupational Safety and Health Committee.

To establish a violence-free workplace, the risk factors that can perpetrate a covert violence incident, either from a patient or relative, a member of the medical staff, a member of the nursing staff, or from a management level, need to be considered and a risk control action plan established to identify risks and the likelihood that they may escalate into covert violence. The basic plan in Appendix D can be adapted to fit any health campus, be it a hospital, clinic or worksite office.

5.5.3.2. Awareness of doctors' preferences

Wherever possible a nurse needs to be aware of doctors' preferences as to drug administration, pre-operative and post-operative care. Individual preference lists should be kept current; indeed in the five major hospitals in metropolitan Western Australia there is a protocol that these preferences be checked yearly and countersigned by the doctor/s involved. By a nurse being aware of these preferences, the admission process would be simplified and may prevent some angst amongst medicos towards nurses (occasionally expressed in the hearing of a patient), and allowing the smoother running of a ward or unit.

5.5.3.3. Awareness of preadmission notes

A nurse is responsible for ensuring, as far as possible, the smooth admission process of a patient. This includes knowing beforehand any possible problem with patient understanding, mobility, physical size and language problem. These may be made on alert from pre-admission phone calls or interviews or on the front of admission request forms sent in to the hospital or clinic from a doctor's office. This knowledge may result in the arrangement of actual bed style (possibly with rails, etc), suitable seating and facilities for a carer or

family member, and the prearrangement of an interpreter if necessary.

5.5.3.4. Liaison with medical staff

With reference to medical staff, the nurse also has a responsibility to inform them if there is a continual problem with pre-admission information given in the doctors' rooms. This not to create problems between the nurses and doctors, but simply to facilitate easier admissions. There have been incidences where the researcher has questioned a patient to find that the information given in writing by the doctor was for another unit at another hospital, and many aspects of it were not relevant to that admission or that unit. When this was discussed with the doctor, he made efforts to ensure that the right information was given at future consultations.

5.5.3.5. Communication with other staff

A nurse has obligations to her fellow nurses. This may be a form of respect in calling in sick when genuinely unable to work a shift, rather than being unable to take their full share of responsibilities for the day, forcing another into a larger workload. Respect should also be shown to another's religious or cultural differences (see Lois' and Clare's stories, research report 4.3.4.).

Respect also involves talking with each other. Incidences which happen on the ward may be diffused if staff would discuss them. For instance, Keely had a problem with a person from another culture. She originally worried that his actions were played against her as an individual, but when speaking to other staff members she found that he treated all female staff the same way. This seemed to diffuse the situation for her, and rather than seeing him specifically as a rude, arrogant, maybe ungrateful person, she was able to allow space for a cultural difference. When Bernie asked other staff she found that

all had had difficulties with the particular doctor she cited. It made her angry to think that no-one else had made an official complaint, but at least it showed that he was not targeting her in particular. When Lois and Clare asked their colleagues they found that the nurse who offended them had actually offended others as well (research report 4.3.4). This meant for them that this was a part of her daily habit – the airing of her religious views and canvassing others for their's. If only these incidences had been reported or at least discussed when they first happened, both the patients and staff involved may have reacted differently by not taking offence or being challenged or hurt in any way. Unfortunately this was not the case.

5.6. Management Power and Powerlessness

5.6.1. *Management power*

'Management' in this research refers to senior staff members who hold positions such as Director of Nursing, Ward Managers and those responsible for the staffing, financing and discipline of the hospital or clinic. With these three aspects of 'control' management would appear to most nurses as being all powerful, with the apparent right to hire and fire, to spend money or not, to make or alter staffing rosters, to discourage staff to complain about their lot and to halt dissention and thereby to promote further oppression to those of less senior standing. Several of the respondents related that, even though they had discussed their covert violence episodes with senior staff and managers this manager either refused to do anything about it or told the staff member to ignore the problem or the problem person. In the stories provided by Western Australian nurses for this research study, rarely was there a feeling of support or vindication for their actions or reactions from management staff members. Cully (2008, p.86) wrote that it was important that managers "react swiftly to reports of bullying."

5.6.2. *Management Powerlessness*

Like all users and workers of the healthcare system, management can often find themselves powerless against bureaucracy and people's demands and idiosyncrasies. Economic constraints due to lack of funding by the Health Department may be traced back to insufficient funding from both the federal and state governments.   It is at their desks that the buck stops as far as the health care campus is concerned. The employer is ultimately responsible for the ethical, legal, financial and safety issues that are the concerns of health centres. They are responsible to the public to ensure that proper care and due respect is given to them by all staff members, to the doctors to maintain their professional link with the service and to keep them as happy as possible with the facilities that are on offer, and to the government's health department in relation to the spending of their budgets and bed states, surgical throughputs and misconduct issues of all staff.

Managers appear to be in a no win situation as far as other staff are concerned, with renovations/repairs needing constant review yet bound by budget constraints, staff leaving because of discouragement, burnout or other health issues, doctors complaining about poor equipment due to lack of finances to replace, repair or maintain equipment so that it is safe and able to be used appropriately and from members of the public who feel they have been wronged by the health service in some way. However, they also have a set of obligations to bring to the workplace in order for it to run at its most optimum level.

5.6.3. *Management Obligations*

Unfortunately, the 'buck stops' at the top of any organisation, and, as diverse as a hospital or clinic may be in its programmes and facilities, management is where the topic of covert violence must be initially addressed. Each user of the service is affected by covert

violence and must be considered when policies against it are made. In order to do this, there needs to be an assessment of those things that make life difficult for patients and staff, and this includes not only actual personal concerns, but also extends even as far as the general environment of a place. These are referred to in the Risk Control Action Plan (Appendix D). For example, if a waiting room or ward is uncomfortable to wait or work in, then already the staff, patients and their relatives are aggravated resulting in aggression that is projected towards the staff where in fact it is as a result of poor environmental factors rather than the actual nursing itself. By addressing the environment as a whole, the patient's experience of their hospital or clinic attendance may be less of a trial for them. Also, the working life of staff may be at the same time enhanced.

5.6.3.1. Availability of Director of Nursing to patients and staff

The first issue is one of actually listening to what is being discussed around the health campus. This includes patients, their relatives, and all staff. The old adage of 'My door is always open" no longer applies. It has been shown, even in this research, that staff or patients will not just 'wander in' to chat. There needs to be suitable access by all. The first group that needs to be accommodated is the patients and their relatives. Although all of their anxieties cannot be soothed during an admission, it would be prudent for any management team to actually address those of most importance and most irritating to their clients and patients.

5.6.3.2. Parking issues

Another problem for patients and their supporters is one of parking. In this there are three aspects to be considered. The first is the number of car park spaces available and the closeness to the hospital or clinic. Where there are staff and client car parking

combined, often there are few close parks for patients, and at some hospitals, it is necessary to park several streets away. Car parks needs to be close to the admission area, and if possible, the actual number of places not being in competition with staff.

Secondly, there is the issue of parking costs. Thomas (2009, p9) cites three city and suburban hospitals as charging from $3 per hour ($15/day), $1.50/hour ($10/day) to some at 60c/hour. She states that because of these prices, SCGH and Fremantle Hospitals took $3.5 million in a year, the QEII site $1.7 million in 2007-8, and Royal Perth Hospital $1 million in the same time. In her article, Thomas quotes Health Consumers' Council Director as saying that '…a lack of parking at hospitals was the biggest complaint of patients.' In the article several hospital spokesmen stated that the money was used in providing better parking facilities, but it seems parking facilities are not improving enough to demonstrate to customers that the revenue is used for this purpose. When patients attend clinics or are admitted for procedures, it is rarely possible to determine how long each will be at the actual hospital or clinic, so parking costs can loom large for an already distressed patient. Outpatients and Emergency Care patients and their relatives also have to go our frequently to the carpark to put more money in the parking meter when the time for their treatment or discharge is delayed. One hospital has solved this problem by giving a 'registered' patient a specially stamped coupon to place on the windscreen of their car so that they can park for free for the genuine duration of their stay. Visitors still have to pay, but at least the patient and their immediate family are saved this hassle.

Along with the cost of parking is the problem of security. Most hospitals or hospital carparks are targets for break-ins or damage. This even occurs in 'patrolled' carparks. Realizing the costs involved, there should be security staff visible around the carpark sites to deter would-be villains. Several times over the years the researcher has met discharged patients as they come back into the health facility to report that their car had been damaged or tyres deflated whilst they were being treated. A secure gated enclosure

would be the best option, but the cost to the campus would be prohibitive.

5.6.3.3. Printed information

Most hospitals and clinics offer pamphlets on which a client or relative can write about their experiences in their hospital or clinic setting. It usually includes a system of rating various aspects of care on a 1-10 scale with a small section at the end for comments. These are usually collected and correlated on a monthly basis and each department or unit is targeted for 'improvement'. Although there is opportunity for anonymity for the patient to state their concerns and complaints, perhaps there needs to be an opportunity for that person to speak to individuals or to the ward staff directly.

The second part of this is to act on the results of these surveys as quickly and sympathetically as possible. Patients are concerned, not only with the procedure for which they are being admitted, but are also affected by the environment in which they have to wait. These issues are of vital interest to the patient in that, once they have arrived at the hospital or clinic, or have been admitted to a ward or unit, they often feel somewhat trapped, not aware that they can leave or change their mind about having their procedure. So they wait, and often it is this waiting time, in itself, which can cause most distress to a patient. Most people are prepared to wait for what they consider a reasonable time, even excusing longer times when it is obvious that there has been a problem within the ward or unit, but it can be a very frustrating experience for someone who is already out of their comfort zone, just being in hospital, just being sick, resulting in a rise in anxiety.

There was much press coverage in 2009 about waiting times patients have to endure, especially in the public health system. In March there was an inquest into the death of a lady with breast cancer (Jones, 2009, p39). The issue was not so much that she died of her

cancer, but that she had to wait for up to an hour and a half in an emergency department for treatment for pain and a fever, conditions that should have been treated within thirty minutes. The emergency doctor estimated that '… up to 40% of those given a triage level of three [given to patients with a potentially life-'threatening condition] were not being seen within 30 minutes because of lack of space in the emergency department, too few staff and a lack of hospital beds to move patients from the emergency departments.'

Similarly, in April details were given through Freedom of Information that in the previous year, 7215 patients who attended emergency departments across all the major hospitals in Western Australia had left before treatment, often without even seeing a doctor. Their reasons for leaving were varied, but the majority of the patients simply got tired of waiting, accusing staff of taking too long to assess and transfer patients. According to information from the Health Department by 2011 all major hospitals will attempt to either admit or discharge 98% of their patients within four hours. This sounds promising, but even a four hour wait for 'service' is a long time especially if it involves an emergency situation. It will still be a *'…major challenge' to facilitate this.* (O'Leary, 2009, p19).

In June 2009, it was reported that 'WA hospitals were among the slowest at seeing patients who were assessed into one of five triage categories depending on the seriousness of their condition. Even patients who *'…needed resuscitation – the most serious category - …one per cent faced a delay.'*(Tillett, 2009. p13).   In 2010 the newspaper reported that there is still an '*unacceptably long'* waiting time, with only 70-75% of patients being either admitted or discharged within four hours. (O'Leary, 2010, p10).

On a standard ward or unit, the situation may not be too different. One may be admitted for a procedure or surgical operation which is listed as 'morning' as early as 6.30am and, because they are last on the list, may not be seen by a doctor before 11a.m. or even later. An afternoon admission may arrive at 10a.m. and not be seen until

4p.m. or 5p.m. This is a very long time for an anxious person to wait. Realizing that there may be some pre-op or pre-procedure management necessary, there may be yet a method of reassigning waiting times for each patient. A realistic theatre list for each surgeon or proceduralist taking into account the true length of the procedure should be assessed. Of course, this does not allow for any misfortunes or unforeseen circumstances that may arise, but it would still be a feasible exercise. For example, if a particular surgeon takes fifty minutes for a piece of surgery, and his list is timed for four hours, then it is unrealistic to expect that he can perform six or seven procedures in time, allowing for anaesthetic induction and post-intubation times. So that surgeon should only be 'allowed' four procedures. However, with hospital finances and bed numbers of importance to funding, often the theatre lists run overtime resulting in anxious patients and relatives, tired and overworked nurses and doctors, and general aggravation all around. Realistic theatre and procedure lists would be a start in perhaps readjusting times for a patient to be admitted.

5.6.3.4. Attention to reports of violence

All reported incidences of covert violence need to be taken seriously. The national and state governments' pamphlets refer to workplace bullying as being identified as 'repeated' incidences, but even a single incident could be a pointer towards a potential undercurrent of covert violence. The once-accepted tenet that covert violence was just 'part of the job' and either one 'learnt to deal with it or left the profession' is no longer acceptable, and even once-off incident should be recorded and filed appropriately.

A strategy to ensure that all reports of covert violence are recognised and, where necessary, acted upon, is proposed in Appendix E. Each reported incident of covert violence should be recorded in the appropriate column and kept on file until dealt with completely and

then kept for further auditing. Regular auditing of these figures will assist with the collation of Occupational Health and Safety statistics for each ward or unit, and for the health campus as a whole.

5.6.3.5. Fair allocation of educational opportunities

The hospital or clinic is responsible to ensure that all staff are kept up to date with education sessions, regardless of their working rosters. These sessions should not only include education topics about medical conditions, medication updates, but also changes to hospital policies, procedures, budget constraints and new equipment, as well as issues dealing with aggression and covert violence.

5.7. Government Power in Legislation

5.7.1. Western Australian Legislation

Regardless of the situation each group of perpetrators and victims, all who use or are employed in a health campus in Western Australia are responsible for their actions and are subject to the legislations of the Western Australian (W.A.) Occupational Health and Safety Act (1984) and Occupational Safety and Health Regulations (1996) and of WorkSafe WA requirements for a workplace free from aggression and harassment. Each state of the Australian federation has similar legislation. Regardless, though, of the situation each group of perpetrators and victims, all who use or are employed in a health campus are responsible for their actions and are subject to the legislations of the Occupational Health and Safety Act (1984) and, in Western Australia, of WorkSafe WA requirements for a workplace free from aggression and harassment. The following table outlines the information available to all users, employees and employers of any health campus in the State of Western Australia.

Table 6: Western Australian Legislation and web sites

Name	Link	Type of Information	Description
WorkSafe W.A.	http://ww.commerce.wa.gov.au/ workSafe/Contents/Safety.Topics	Workplace Bullying	- Definition - Informal and formal - Steps to prevent workplace bullying - Duties of employers under the Occupational Safety and Health Act (1984) to provide a safe working site - Who can lodge an enquiry with WorkSafe
WorkSafe W.A.	http://www.commerce.wa.gov.au/ Worksafe /PDF/Codes- of – Practice	Code of Practice 2010 Violence, aggression and bullying at work	- Information on risk assessment of bullying episodes - Guidelines for developing prevention strategies - How to develop a complaints checklist
WorkSafe W.A.	http://www.commerce.wa.gov.au/ WorkSafe/Contents/Safety-Topics/Stress	Outline of legislation regarding stress	- Definition - General care of employer - Factors that can affect workplace stress - How to report stress
		PDF file for all workers on stress	- What isn't stress - What can be done by an individual to deal with workplace stress - Contact information for WorkSafeW.A.
Safety and Health		Workplace Safety and Health Act 1984 (W.A.) _____ Occupational Safety and Health Regulations (1996 (W.A.)	- Promote safety at work - Protect people against hazards - Assist in securing safe and hygienic work environments - Requirement to identify workplace hazards, assess the risk of these hazards causing harm, and control the risks
Anti-discrimin-ation legislation		Equal Opportunity Act 1984 _____ Criminal Code Chapter X1 Spent Convictions Act 1988	It is illegal to discriminate on the basis of: - Sex or gender, transgender - Pregnancy, breast-feeding - Race, colour, ethnic origin - Religious belief, age, political belief, disability or impairment. - Spent criminal convictions

All this information is easy to find and can be printed out in languages other than English. These publications on preventing workplace bullying provide examples of stress and bullying and

outline clearly how to document, report and deal with these workplace phenomena. The issue of what constitutes 'covert violence', however, is of some concern. The legislation recognises that 'bullying' as 'repeated, unreasonable, inappropriate behaviour towards [another]', but in some of the stories, the incident is a 'once-off' and so would not fit the criteria of WorkSafe W.A. Julie's issue with an anaesthetist was a 'once-off' but it left her angry, frustrated and reluctant to work with him again (research report 4.3.4.).

The legislation continues '...single incidences of this type should not be ignored'. However, in reality, a single incidence is rarely considered worth following up, and so single similar incidences may occur to several people before a ward manager may deduce a pattern of unacceptable behaviour from the perpetrator. By then these several people have had their self-esteem damaged, their work may have suffered, and they may be considering changing wards or units, or even workplaces. The Code of Practice, (2010) states that reports of trivial examples of bullying may be indicative of deeper problems with bullying within the workplace, and so passing off Julie's concerns, as with Shirley's complaints about the ineffective air-conditioning as trivial, may actually enhance the problems of bullying in the respective workplaces.

There are also details in the Code of Practice on Violence, aggression and bullying at work (2010) in dealing with bullying on how to contact suitable people from WorkSafe W.A. should there be any concerns or further questions on these topics. There is no reason why all employers and employees should feel lost as to what to do when covert violence occurs in the workplace. In three hospitals the researcher visited, the contact people's photos and contact numbers were posted in the staff dining rooms. Not all staff eat in the dining rooms, so, in reality, not all staff are aware of those to approach regarding problems with covert violence. Perhaps the most effective method would be to have a copy of the poster in every ward or unit, rather than just one in a dining room.

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Also, the internet sites may not be readily available during work time for employees to access although Regulation 3.2 of the Occupational Safety and Health Regulations, 1996 states that there is to be 'available for ...perusal and up to date copy of

(a) the Act; and

(b) these regulations; and

(c) all Australian Standards, Australian/New Zealand Standards and NOHSC documents or parts of those Standards or documents referred to in these regulations that apply to that workplace; and

(d) all codes of practice approved under section 57 of the Act that apply to that workplace.

Many nurses do not know that, like their employers, they have a responsibility to ensure, where possible, a safe workplace. Most nurses would be able to discuss stress levels at work and bullying episodes, but very few may be able to cite relevant legislation forbidding such activities.

There have been some advances in remedying episodes of covert violence in nursing since the pilot study was completed. In most hospital and clinic waiting rooms there are posters which condemn any forms of covert violence that is directed towards any member of staff and this appears to have had some positive effect on patients and their relatives, as well as on visitors to the facility, but very little appears to have been done to minimise infra-staff violence. The collected data has shown that intfra-staff violence has increased in volume and in intensity. There were no reports in the respondents' stories of a nurse being sacked, only examples where the perpetrator of covert violence was simply transferred to other wards or units. The medical practitioner described in 4.4.1 did not have his contract renewed with the hospital.

The problem, then, is that, despite documentation to the contrary, and relevant slide shows and lectures, covert violence is not

necessarily taken seriously by nurses, particularly those in management roles. It remains under-reported and undervalued as a reason for staff discontent, stress, low productivity, and early retirements or transfers from campus to campus.

A second issue is that some elements of covert violence are considered important whereas others are not. For example, Hammond, (2011, p30) cites the Equal Opportunity Commissioner, Yvonne Henderson as saying 'while the commission could act on issues such as sexual harassment it could do nothing about bullying', although more than five percent of inquiries to the Commission in the last financial year had been related to bullying in the workplace. 'If bullying was a ground under our Act (the Equal Opportunity Act) we could do something about it. Right now we can't formally investigate it.' This failure to amend the Act or even acknowledge it as a significant form of covert violence leaves the Western Australian legislation lacking and inadequate.

In respect to the anti-discrimination legislation, although it is diverse in its summary of prohibited grounds for discrimination, it would seem, that the legislation is either inadequate or not taken seriously, either by employers and employees, perhaps because the actual topic of covert violence is not taken as seriously as it should be. To be effective, these strategies would need to have the total acceptance and agreement from local and government agencies.

However, all this information is readily available, either in printed form or via the internet.

Other Australian states have similar legislations, related to workplace violence and how to deal with it.

5.7.2. Legislation in other Australian states

Table 7: South Australia government legislation and web sites

NAME	LINK	INFORMATION	DESCRIPTION
SafeWork S.A.	http://www.safework.sa.gov/uploaded files/pdf	Slide show on bullying	• Definition of workplace bullying • Safe work act • Risk factors • Information for employers on handling complaints
SafeWork S.A.,	http://safework,sa,au/uploaded files	Training Resource kit on on bullying and harassment	• A summary of laws that protect workers • Effects of bullying and harassment • How to deal with workplace bullying and other forms of violence
Worksafe S.A.	http://safework.sa.au/uploaded files	Slide show on stress	• Definition of stress • Goal setting for personal power control
Health and Safety		Workplace Health and Safety Bill 2011	• Employers are to provide, as far as practicable, a safe working environment, safe plants and care of substances
Anti-discrimin-ation legislation		Equal Opportunity Act 1984 _____ Racial Vilification Act 1996 _____ Civil Liability Act 1936	It is illegal to discriminate against a person on the basis of • Sex or gender • Pregnancy or breast-feeding • Disability, age, marital state. _____ • Race, colour, ethnicity • Political or religious belief • People are protected from prosecution if they offer a reasonable standard of care to humans, animals and property, as long as injury or death is not caused by a wrongful act, neglect or by default

Again, the definition of bullying is 'repeated episodes' and this may not always be the case for covert violence. However, these documents are easy to access if one has computer access. Like Western Australian legislation, South Australian legislation is inadequate to deal effectively with covert violence experienced in the nursing workplace.

Table 8: Queensland government legislation and web sites

NAME	*LINK*	*INFORMATION*	*DESCRIPTION*
Workplace Health and Safety Queensland	*http://www.deir.qld.gov.au/workplace/resources*	Poster – 'Workplace Bullying, if you don't step in, you're supporting it'.	• Large, colourful poster suitable to hang in all public areas in a health service, as well as in common nursing areas such as change rooms, cafeteria, etc.
Workplace Health and Safety Queensland	*http://www.deir.qld.gov.au/workplace subjects*	*Occupational Violence Awareness Report*	• *Physical and psychological effects of violence* • *High risk situations* • *How to react to a violent situation*
Health and Safety		*Workplace Health and Safety Act 2011 (Qld) (came into effect on January 1, 2012) replacing the Workplace Health and Safety Act 1995 (Qld)*	• *The objective is to ensure freedom from disease and injury and the risk of disease and injury caused by workplaces, workplace activities or specified high-risk plant and substances (s7)*
Anti-discrimination legislation		*Anti-discrimination Act 1991*	*There is to be no discrimination based on* • *Sex or gender* • *Pregnancy or breast-feeding* • *Disability, age, marital status* • *Union membership* • *Political or religious belief*

The two posters 'Bullying is Not On' and 'Bullying – if you don't step in, you're supporting it' are excellent – large, colourful and to the point. They lay the 'blame' for a culture of bullying and covert violence on every person in the workplace, and therefore each has a responsibility to speak up about it. Health centres nation-wide would all benefit from using them. It may also make a good cover page or insertion for patient information brochures that are given or posted out to prospective patients prior to admission.

Table 9: Tasmanian government legislation and web sites

NAME	LINK	INFORMATION	DESCRIPTION
Workplace Standards Tasmania	http://www.wst.tas.gov/data assets	Workplace bullying and response to complaints	• Definition of bullying • Duty of employees • How to make a complaint about workplace bullying
Workplace Standards Tasmania	http://www.wst.tas.gov/data/assets/pdf	Guide on bullying for all workers and employers	• Bullying Policy • How to conduct an investigation • Disciplinary actions
Workplace Standards Tasmania	http://www.wst.tas.gov.au/data/assets /0020/146252/GB252.pdf	Workplace Stress – a Workplace booklet for employers and employees	• Definition of stress • Short and long term effects • Legal actions for employers • Risk assessment

Health and Safety		Tasmanian Health and Safety Act 2011, which came into use on January 1, 2012, replacing the Workplace Health and Safety Act 1995 (Tas)	• Aim is to provide for the health and safety of persons employed in, engaged in or affected by industry.
Anti-discrimination legislation		Antidiscrimination Act 1998	It is illegal to discriminate against a person on the basis of: • Sex or gender • Pregnancy or breast-feeding • Race, colour, ethnicity • Irrelevant criminal record • Irrelevant medical record • Physical or mental disability • Age, political or religious belief • Union membership or activity

Tasmania has excellent written guides to workplace bullying. They give clear definitions of what is and what is not bullying, and stress and how to recognise and deal with it. They recognise that employees must take some responsibility in making their workplace as 'bullying-free' as possible by recording and reporting incidences as they arise. The brochures also accept that sometimes it is hard to report incidences of bullying to a supervisor or manager if they, themselves, are responsible for the covert violence. Normally Workplace Standards will only investigate a matter if it has not been resolved to satisfaction, but in the case where the perpetrator is a manager or supervisor, there is the assurance that this, normally first step, can be omitted allowing for a fairer outcome for all concerned.

Stress is also recognised as being one element of covert violence. The Standards Tasmania booklet on stress is very well written and considers both the long and short term effects of workplace stress. It highlights the responsibilities of employers to minimise these effects on their employees as much as possible. In a health care setting, this booklet should be made available in printed form for all employees. Although there is recognition of stress as a health and safety issue in the Western Australian PDF file from Worksafe W.A., the Tasmanian booklet is more detailed, and perhaps a combination of information from both the Tasmanian booklet and the Western Australian documents could be combined to present a more comprehensive strategy for recognising and dealing with workplace stress, particularly in the nursing field.

Table 10: Victorian government legislation and web sites

NAME	LINK	INFORMATION	DESCRIPTION
Work Safe Victoria	http://www.worksafe.vic.gov.au/wps/wcm/connect/359448040	Evaluation of Summary findings of incidences of workplace bullying in Victoria	• Workplace bullying statistics • Reporting procedures • Bullying policies • Examples of personal experiences of bullying
Work Safe Victoria	http://www.worksafe.vic.gov.au/wps/wcm/connect/internet/wsinternet WorkSafe/Home/Safety+ Health Presentation Topics	Occupational violence website	• Risk factors • Definition of external And intrusive occupational violence
Work Safe Victoria	http://www.worksafe.vic.gov.au/wps/wcm/connect2e64fc004071f6e4b7fbffe1fb554c40/risk+management+Template.doc?MOD=AJPERES	Work related stress prevention booklet	• Stress management worksheet • Identification of work related stress hazards • Assessing and control of stress risks
Health and Safety		Occupational Health and Safety Act 2004 (Vic.)	• The object is to secure the health and safety of employees; eliminate, at the source, risks to health and safety; ensure the health and safety of the public and provide a consultative framework for managing workplace health and safety.
Anti-discrimination legislation		Equal Opportunity Act 1995 Racial and Religious Tolerance Act 2001	It is illegal to discriminate against a person on the basis of: • Sex or gender • Pregnancy or breastfeeding • Political belief • Employment activity • Marital status, age • Disability or impairment • Union membership • Physical features. • Colour, ethnicity, religion

The first three documents in Table 9 are easily accessible via the internet. They are short, to-the-point publications. One difference is that covert violence or bullying is not specifically defined as a 'repeated' action, but appears to accept once-off incidences as examples of unacceptable behaviour towards workers. A second difference is the recording of a specific workplace where bullying amongst staff was described as 'toxic'. The employers apparently did not do enough to remedy the problem, and so there were heavy fines given to the company itself ($200,000), to the company director ($30,00) and to three employees ($85,000). Although other states' publications [except Western Australia (Hammond, 2011 p30] accept that it may be necessary to make workplace bullying a legal issue, this appears to be the only one with evidence of it having been encountered.

Table 11: New South Wales government legislation and websites

NAME	LINK	INFORMATION	DESCRIPTION
WorkCover Authority of New South Wales	http://www.workcover.nsw. Gov.au/healthsafetytopics/ Psychosocialissues/Pages /Bullying.aspx	Website for bullying	• Examples of forms of bullying • Contact number for further information
WorkCover Authority of New South Wales	http://www.workcover.nsw. Gov.au/formspublications /publications/Documents/ violence_workplace_guide_0 070.pdf	WorkCover Watching Out For You guide. Pdf	• How to identify, assess and control risks • Flow charts • How to eliminate hazards • Guidelines to minimise violence
WorkCover Authority of New South Wales	http://workcover.nsw.gov.au/h ealth/safety/healthsafety topics/Psychosocialissues	Website page on stress	• Sources of work related stress • Examples of subtle stressors • Contact number information
Work Cover Authority of New South Wales	http://www.workcover.nsw. Gov.au/formspublications/pub lications/Documents/bullying _risk_indicator_2236.pdf	Bullying risk pdf file	• Bullying risk indicator diagram • Organisational change • Negative leadership styles • Inadequate or absent supervision
Health and Safety		Work Safety and health Act 2011 of N.S.W.	• There is a general obligation for an employer to ensure the health, safety and welfare of all employees and persons other than employees are not exposed to risks to their health or safety arising from the conduct of the employer's undertaking at the employer's place of work
Anti-discrimination legislation		Anti-discrimination Act 1977 _____ Criminal Records Act 1991	It is illegal to discriminate against a person on the basis of: • Sex or gender • Pregnancy or breastfeeding • Race, colour, ethnicity • Political or religious belief • Disability or impairment • Age, marital status • Union membership. _____ It is illegal to discriminate against a person who, having committed a relatively minor offence, completes a period of crime-free behaviour or has the conviction quashed or pardoned

The New South Wales publications are easy to access via the internet and cover the topic of workplace violence/bullying well. The information on identifying risks of workplace bullying and the flow charts showing how to follow-up a complaint is simple to understand and easy to initiate. These documents could be amalgamated with those from WorkSafe W.A. to make a more comprehensive overview of bullying and stress that occur in nursing, and, if applied consistently in the health services, could prevent, or at least discourage, covert violence in nursing.

Each of the states has legislation against workplace violence, bullying and stress

identification and management. These files and pages are freely and easily obtainable either directly online and also available from union representatives and the Occupational Safety and Health Committees on health campuses. The legislation is in print, but it would seem that very rarely is there any attempt to pursue culprits. It is also a requirement that all health campuses show evidence that the topic has been discussed in a clinic/classroom situation so that all employees are aware of the risks, results and remedies for workplace violence. However, in reality, this may only be a token presentation. For example, the researcher has had the experience of being asked, with ten other nurses, to take a computer-generated test on the topic of bullying, which was circulating around the suburban hospitals. It had twenty questions, each with multiple choice answers, on what was bullying and how to control it in the workplace. A senior member of staff stood nearby and answered each question for the researcher and others who were 'taking' the test. Having completed the questions, all were given a 100% pass rate and dismissed before the next group of ten were admitted. No discussion was given about the answers, nor whether there was any disagreement about them. Staff names were ticked off against a master sheet and so this constituted the monthly education session, this time on bullying in the workplace.

From this experience alone, it would appear that in this particular workplace, the topic of bullying was just one to cover for statistical purposes, rather than a truly educational and practical experience. The hospital was fulfilling its duty to cover the topic, could prove that it was done, and yet there appeared to be no real understanding of the true impact of workplace violence could have on staff, their patients and families. It was treated as a 'fill-in' between other educational sessions.

Although not related to nursing, there was a similar situation at Longford in the Victorian La Trobe Valley in September, 1998 where an ESSO gas plant exploded killing 2 men and injuring 8 and the city of Melbourne had its gas supply cut for 2 weeks.

During the Royal Commission that followed, ESSO blamed operator and supervisor error in mixing cold air with warm oil which ultimately caused a heat exchanger to fracture. Supervisors and operators were given training in the form of a lecture

followed by a written quiz, the results of which were either a 'pass' or a 'need for re-explanation,' or 'coaching required'. The training supervisor ticked off the relevant answers and, although he offered extra training and explanation to those who did not achieve the required results, according to one operator *'It took gumption to ask for a re-explanation' (*Hopkins, 2000, p18). Consequently men apparently wrote correct answers to questions but the real concepts they did not understand. Counsel for Esso blamed one operator's 'lack of integrity in providing and answer he knew was required without having a clear idea of what the answer meant' (Hopkins, 2000, p19). The Royal Commission refuted ESSO's claim of 'operator error', instead laying the blame on inadequate knowledge due to inadequate training. ESSO was fined 2 million dollars.

The researcher draws a parallel between the Longford disaster and the inadequate training given on the topic of bullying to nurses in order to fulfil a Health Department requirement for training. This lack of adequate training may not result in deaths or injuries as at Longford, but there is a culture of writing or ticking the right answers in order to pass rather than actually understanding the topic.

Coupled with these specific state papers and legislation there is also a set of Commonwealth Government publications to which workplaces are to adhere. They, too, are readily accessible in print or online through the internet.

7.3. *Commonwealth Government legislation*

Table 11: ComCare legislation and Commonwealth government websites

NAME	LINK	INFORMATION	DESCRIPTION
COMCARE For all states	http://ww.comcare.gov.au/safety_and_preventionhealth_and_safety_topics/bullying/workplace_campaign	Bullying campaign	• Three phases – education, investigation, report • To develop awareness of workplace bullying and its consequences
COMCARE for all states	http://www.comcarfe.giv.au/data/assets/pdf_file0020/41267/Associate_Professor_Tony/LaMontagne.pdf	Stress slide show	• Effectiveness of intervention • Stress studies graph • Policy and practice • Future direction
COMCARE for all states	http://www.comcare.gov.au/data/assets/pdffile/002041285/Professor_Duncan_Chappell	Workshop presentation on violence	• Dealing with aggressive clients • How to look for hazards • Health problems related to stress • Pictures of major hazards
COMCARE for all states	http://www.comcare.gov.au/data/assets/pdffiles/007/50389/Psychological_injury_and_management.pdf.	Work related injuries	• Rehabilitation and the worker • Psychological injury costs • Employer responsibilities • Injury risks • Prevention of work-related injuries and ill-health caused by bullying or other causes
Anti-discrimination legislation		Racial Discrimination Act 1975 _____ Sex Discrimination Act 1984_____ Australian Human Rights Commission Act 1992 Disability Discrimination Act 1999_____ Age Discrimination Act 2004_____ Model Work Health and Safety Act 2011 supported by Model Regulations and 12 Codes of Practice 7 of which are relevant to nursing,	It is illegal to discriminate against a person on the basis of: • Race, Colour, Ethnicity_____ • Sex or gender_____- • Pregnancy or breastfeeding • Political or religious belief • Irrelevant criminal record • Irrelevant medical record_____ • Age _____ • General obligations on a person who conducts a business to ensure, where practicable, the health and safety of workers under their control

The Model Work Health and Safety Act (2011) commands 'due diligence' on behalf of the business owner to provide a safe working environment for those who work on the premises, be they direct employees or subcontractors. The business owner is to use appropriate resources and processes to minimise or eliminate any risk to health and safety. This Act may be the appropriate basis on which to address the issue of covert violence in nursing Australia-wide.

There are also a number of publications and fact sheets provided online by the Commonwealth Government, with specific ones for employers and employees, but there is no one cohesive health, safety and welfare legislation that covers all the states.

One problem with all these publications, be they State or Commonwealth Government generated, is that they require a computer to access them, and in some hospitals and clinics, only the ward or unit managers have such open internet allowance. One solution would be to give each employee copies of the publications which would be an unwieldy package, and may be discarded or stowed away. A more practical method would be to have a specific folder, similar to that of Infection Control, on each ward or unit with the relevant pamphlets and brochures available for all to read. In some workplaces these are available in folder form except the file is kept in the manager's office which is locked when the manager is not on duty, so access to the information is not always possible.

A second problem is that not all states will take on board the model Act at the same time. It was anticipated that the Act will be introduced in January 2012 but Western Australia has disagreed with the proposed legislation allowing the right of entry to workplaces of union representatives. Burke, McDade and Sykes (2011, p.277) contends therefore that Western Australia will not introduce this Act on the January 2010 start date. There are also other States, such as Victoria, that are still refining their new workplace health and safety legislation before it is passed into law.

However, in spite of these documents being available to every workplace, employer and employee, workplace violence – bullying and stress – are still being treated as 'accidental' or 'inconsequential' with often the victim being made feel responsible rather than the perpetrator. However, from this research it is apparent that covert violence is more than just bullying and stress, and yet none of the legislations assessed address this situation. Therefore the legislation does not appear to be of any credibility when, from figures of both the

2003 Pilot Study and this research, covert violence in nursing is not addressed fully and so continues to be a major concern for staff.

5.7.4. *Legal Obligations*

This category has not been included in Figure 4 because it is an external element, but it is nevertheless, an important issue that may need to be addressed.

5.7.4.1. Safe working environment

It is a legal requirement for all workplaces in Western Australia to be safe environments, yet from the testimonies given in this research, those from internationally published literature and States and Commonwealth legislations, the incidences of covert violence experienced by nurses in Western Australia continue to rise. Covert violence can no longer be considered just 'part of the job' and needs to be taken seriously. Posters abound in patient areas throughout Western Australian health campuses stating that any violence will not be tolerated, but even so, little, if anything, is ever really settled. Certainly in the city, there are guards and security staff in high-stress areas such as Emergency Departments, and they do expel noisy, disruptive folk, but in smaller hospitals or country clinics these back-up staff are not readily available, and so staff need to deal with them personally. Unfortunately often the same people cause the same problems, but rarely are they banned from a health campus, as are persistent trouble-makers on the Isle of Man, where they are actually given or sent a letter stating that they will no longer be treated at one particular hospital, and should they require medical help in the future, they need to attend another hospital or clinic. All health campuses need to take a similar, determined line, regarding disruptive patients and staff, or medical or nursing staff who continuously cause distress to other staff, and disruption to the smooth running of the service.

The whole idea of banning a person from a health campus may take an enormous mind-set change from the usual one of care and nurture by a hospital or clinic, but one that is overdue as far as workplace civility is concerned.

A second consideration is that of a nurse or a health service actually taking a covert violence perpetrator to court as a civil case. Again quite rare but this may have to be the way of the future so that others can see that bullying or violence towards a nurse or any other health worker is not acceptable. Lowe (2011, p.50) cautions that a court would probably only recognise the case if 'all reasonable steps had been taken to prevent bullying and harassment and to deal effectively with any bullying or harassment that occurs.' This puts the onus back on the management staff to ensure that all possible avenues had been exhausted in identifying, addressing and, if necessary, counselling a persistent perpetrator (be they a member of the public or a staff member) The Model Workplace Health and Safety Act 2011 should make this a possibility but it will depend on how determined the States and Commonwealth departments are to make workplaces adhere to the relevant legislation, and perhaps how strong the unions are to enforce the legislation.

5.8. Summary

This research has identified that the causes of covert violence are complex and are affected by power and/or powerlessness. It also shows that there have been changes in the types of covert violence that are present in the Western Australian nursing profession, and that these causes have not yet all been addressed. The Pilot Study reported that most of the incidences of covert violence were perpetrated by patients and their relatives (82.5% combined), doctors were reported in 40% of the incidences, and nurses in 30% of the reports. The main research study shows a decrease in patient and relatives abuse (46% combined), and doctors (in 14% of reports).

However, the figures for this research show there has been an increase in nurses being cited as perpetrators of covert violence (30% in the Pilot Study and 60% in the main research study), and management staff were cited in 80% of the reports in the main research study but not at all in the Pilot Study.

Signage and better understanding of the limits and constraints of the health system in general may have been responsible for the heightened public awareness of the effects of covert violence directed towards hospital staff, but it seems to have had little impact on internal covert violence episodes. Nursing staff members, themselves, are currently instigating the most common incidences of covert violence in nursing.

 All who use a hospital or clinic in some way have an input and are individually responsible, not only for their actions and words, but also for the inherent protection of all who visit, attend or work in the place. Tolerance with, and respect for all, is the ultimate antidotes for episodes of covert violence. Ways of introducing and maintaining respect and fair dealings with people is discussed in the next chapter.

6. CONCLUSIONS AND RECOMMENDATIONS

6.1. Introduction

This research study had two research questions. The answers to these were facilitated by offering an interview with set questions which were answered by fifty (50) nurses. The results were compared to the pilot study. The first question was 'What are the characteristics of covert violence experienced by Western Australian nurses?' From the answers to this question, the researcher has proposed a new definition of 'covert violence' as any act or word that has a negative impact on another's self-esteem, quality of life or ability to perform their allotted tasks. The second research question was 'What are the causes of covert violence as experienced by Western Australian nurses? This was answered in chapter 4. The final section of the research report includes recommendations and a Risk Control Plan based on the findings of this research.

6.2. Recommendations for Risk Control

6.2.1. *Introduction*

There are no short-cut fixes to ensure covert violence does not occur in any workplace, especially in nursing and a zero tolerance philosophy, although excellent in theory, would need to be instituted in a medical/nursing facility in a slow yet determined manner, phased in right across the hospital/clinic system, both public and private. A covert violence-free environment is not only a recipe for a good workplace, but is also a legal responsibility.

There also needs to be a culture of care for each person using the facility, no matter what their status. This was one of three strategies the participants offered the researcher as to how to improve work conditions and limit the opportunity for covert violence (see research section 4.8.5.). Two other suggestions were made – that all

incidences of covert violence be taken seriously by all staff, especially those at a managerial level, and that there be a system of support staff or mentors to assist other members of staff to adjust to new situations or new wards, and to deal with covert violence on a day-to-day basis.

In order to implement such an environment, there needs to be an acceptance of responsibility by all who use the health system, be they patients, doctors, administrators and nurses themselves. Each group of health system users must consider strategies to change a culture where covert violence is accepted as the norm. To accommodate this, a Risk Control Action Plan has been developed that could be used in all workplaces, not just for nursing.

The five themes identified in this risk assessment and Risk Control Action Plan (see Appendix D) add to an already stressful workplace, resulting in potential aggravation of clients, and staff that can lead to episodes of covert violence. However, the comfort and care of patients, their relatives and all staff should be the responsibility of all who use or work in a health campus.

6.2.2. *Towards a better workplace*

This research study has identified the important factors required to establish and maintain a workplace free from covert violence. The first and most important is to develop a mission statement which begins with the concept of a culture of caring.

6.2.3. *Culture of caring*

Each nurse participant accepted that their health campus had a duty of care to their patients and often outlined this in their Mission Statement, but rarely is there any similar reference to caring for staff.

This culture should extend from the Minister for Health to the State Health Department, the hospital board and to all users of the facility.

This would establish a culture of care where all staff, contract staff, patients, relatives and other users of the campus, whether a public or private facility, show respect to each other and thereby ensure a hospital admission and a place of employment co-exist to the benefit of all.

6.2.4. *Provision of adequate resources*

Resources, equipment and workplace conditions need to be constantly updated and relevant to the needs of the changing health system. This could mean simply more trained personnel to adequately perform the duties required over each shift, suitable equipment to manage patients and keep theatre lists rolling, and conditions such as adequate lighting, car park spaces and security and timely attention to occupational health and safety issues. Without these resources, patient care may be compromised, the hospital may not be able to maintain patient lists, and staff may be unable to cope with the rigours of work. Safety of all users of the facility may be jeopardised, making nursing more stressful and may result in longer inpatient stays.

6.2.5. *Establish a teamwork ethos*

Teamwork should be part of the nursing philosophy and aligns with the culture of care. Where it is in place, wards and units work more efficiently, effectively and safely than when one person is expected to work alone. It should be promoted throughout the whole campus, and perhaps rewarded in some way in an effort to encourage it. Wards and units should be considered full of 'our patients' rather than individually labelled 'mine' or 'his/hers'.

6.2.6. Encourage learning

Employees, regardless of their position, need to be kept up-to-date with all types of information, from research, to equipment updates, to changes to hospital policies and protocols. Rosters should be drawn up to allow all staff to attend all lectures and demonstrations, which may involve bringing in agency or pool staff to cover the wards during the times of the lectures. Each staff member then may develop better and more diverse skills, deliver more effective health care, and make them feel more part of the hospital community.

6.2.7. Communicate effectively

Employees must be aware of what is expected of them as far as their nursing is concerned. Effective communication means that management must offer helpful and encouraging feedback on nurses' activities and work performances.

Documentation must be standardised throughout the campus and standard protocols should be adhered to. To facilitate this, there should be written, as well as computer accessible, statements as to what is expected and how to actually fulfil the requirements.

Community members and patients should be encouraged to take part in voluntary work such as helping at the hospital canteen or shop, attending board meetings, and fund raising events.

Patients should be offered brochures on discharge asking for helpful suggestions for making a hospital stay more comfortable, etc. No names need be collected although there should be a provision for name and a contact number for the hospital representative to ring if the patient desires.

These seemingly simple avenues of communication provide a means whereby members of the public and patients can have an input into the workings of a hospital or clinic. It would provide feedback into the

actual effectiveness of care given, and may help implement suitable changes to policies and protocols and services if deemed necessary.

There needs to be a written policy on prevention of covert violence in the workplace that is accessible and used by employees and all people who come to the workplace. This policy should be kept current and include a provision for the monitoring of the effectiveness of the policy. There also needs to be documented, known and used procedures to be followed if episodes of covert violence still occur. Face-to-face staff education must be given on how to effectively use this policy and procedures and on covert violence prevention strategies. These procedures and policies must be evaluated at least annually and, where opportunities for improvement are identified, these should be made if practicable.

The prevention of covert violence needs to be included in staff position description statement of duties and in their performance assessments of work competency. Line managers need to be assessed to ensure that they are competent people managers and will act on reports of covert violence effectively.

6.2.8. *Establish a covert violence-free environment*

Given that there may be differences in expectations due to age, infirmity, culture and drug or mental overlay, as far as is possible, all users of a health facility should be made aware that respect and courtesy is expected from everyone and that each will be held responsible for their own behaviour. This should be reinforced by means of posters and written policies that any disrespectful behaviour will not be tolerated and it may/will be met by that person being ejected from the campus, or not being treated at that facility. Currently around health campuses there are posters which refer to overt physical violence, but these should also include any form of violence, covert or overt. Posters that cite the definition of covert

violence given in this research would be clear, succinct and simple enough for all to understand.

6.2.9. *Provide education on covert violence in the workplace*

This should not be of token value as described in chapter 5, but genuine education on what bullying is and is not, and on stress and other forms of covert violence. There should also be discussions on how to develop strategies to identify and deal with covert violence, how to record incidences and how to address the situation to minimise the effects and duration of the episodes.

6.2.10. *Use of the Risk Control Action Plan*

The risk of covert violence occurring in the health service needs to be analysed and causes identified. All identified risks then need to be controlled. The Risk Control Action Plan (Appendix D) could be adapted to suit any area of any health campus, from cleaning to kitchen to ancillary services such as X-ray or Physiotherapy to Engineering and from nursing. As new risks are identified, as a living document, the plan can be modified. The whole purpose of it is to establish a workplace where covert violence is not accepted, and because of this, the facility can provide a better standard of care for both its patients and its staff.

6.2.11. *Establish Covert Violence Register*

The procedures need to include the use of a covert violence register (Lowe 2011). Appendix G is an example of a Covert Violence Register that can be adapted for use in any health service nation-wide. It is simple to complete, has provision for a time limit for action, if any, and for both the victim and perpetrator to be interviewed with

the intention that the incident be finite yet recorded for auditing purposes or further action should the situation re-arise.

The Covert Violence Register in Appendix G can be used as a tool to recognise incidences of covert violence in nursing, and could be adapted for use in other workplaces. For each section in the Covert Violence Register there is opportunity to register an episode of covert violence by date and by action. For the victim (in this research, the nurse) the action from an incident may be to simply tell the perpetrator to stop the particular behaviour that the nurse has found to be offensive, or to tell another nurse, to tell a senior nurse or to take union or legal action against the perpetrator.

Management response may range from doing nothing to a deferred or immediate action. Again, these are dated to assist in any later Occupational Safety and Health audit of the organisation.

For the perpetrator, the result may range from no action from nurse or management to being red carded, reported to the police or legally prosecuted and these actions are dated.

The final section of the Covert Violence Register [Result Date for Victim, Appendix G] concerns the actual victim and how their report of covert violence was recognised in the long term. Options range from no action taken, to offering counselling to the nurse, transfer to another unit or ward or the offer of any other support thought necessary by nurse and management.

This register shows immediately the number of reports of covert violence in a particular workplace and reflects the seriousness of them on the nurses involved and ensures that action of some sort is taken to remedy the situation. It eliminates the possibility of management ignoring or denying that an episode of covert violence has occurred. It could be used by any department or outside agency such as a union as a paper trail should an incident become an ex-campus issue.

6.3. Responsibilities

It is the researcher's contention that all people who use a health service, be they staff, patients or relatives have a responsibility to themselves and each other to maintain a safe, efficient working environment where each person is valued as an individual and/or as a team member who has a job to perform. The lists presented are not necessarily exhaustive but offer a general idea as to what should be expected of each group of people.

- Patients' Responsibilities:
    - Knowledge of own medications if mentally competent to do so
    - Awareness of procedure to be performed where possible
    - Realistic expectations of admission
    - Courtesy to all
    - Personal education on health issues
    - Responsible behaviour
    - Adherence to advice given by doctors and nurses
    - Networking with community organisations that have wellness programmes (such as weight control or smoking) in an effort to take some responsibility for their health

- Nurses' Responsibilities
    - Provision of a safe working environment
    - Awareness of doctors' preferences
    - Awareness and knowledge of preadmission notes
    - Liaison with medical staff
    - Keep communication with colleagues professional

- Management Responsibilities
    - Provision of safe working environment
    - Availability to patients and staff
    - Correct and relevant printed information for patients
    - Attention to reports of violence
    - Provision, and implementation of an anti- bullying and covert violence prevention policy in written form, along with an effective monitoring system allowing for modification or improvement as required. It should include (Lowe, 2011, p 1049):

        a. a clear rationale;

        b. what is and is not acceptable behaviour towards any other person in the hospital, clinic or health service;

        c. the rights of all employees

        d. the responsibilities of different levels of employees in regard to what they do if they see hear, or otherwise find out about any bullying or harassment;

        e. a brief description of how any bullying or harassment complaints will be dealt with (in a way that encourages people to come forward) and a cross-reference to written complaints procedures, and

        f. what might be the end result of bullying or harassing someone, or of lodging a false or mischievous complaint about bullying or harassment.

        In addition it is a management's responsibility to
    - Have an awareness of personalities of staff
    - Provide a fair allocation of educational opportunities for all employees
    - To foster a climate of care and concern for all

- To monitor covert violence prevention strategies, policies and procedures at least annually and as required for assessment of effectiveness and to make improvements as necessary.

- Doctors' Responsibilities
    - Correct information for patients and families
    - Responsibility to hospital or clinic
    - Consideration of other staff
    - Respectful communication with colleagues

- Legal Responsibilities of health service management include:
    - Provision of a safe working environment
    - Access to legislation and Standards information for all staff

6.3.1. *Summary*

All should recognise that people are stressed for a multitude of reasons and so it behoves everyone to show a climate of care and respect. Noisy children and visitors, as well as noisy staff should be considerate to others using the health service wherever possible, perhaps taking small children away from an area or ward, or maintaining a dedicated 'children's' room' where they can wait and play away from other patients. Patients and their families should respect all staff, understanding that the shortfalls in comfort and privacy may not be under their control. Likewise staff should show care and respect to patients who are often anxious and concerned about upcoming tests and operations, etc. Medical and nursing staff should show respect to each other in the knowledge that each is under stress to perform well, often under difficult and unpredictable circumstances.

People attend health care campuses for many reasons – some because they work there, some because they are in need of medical care, others because they are visiting either staff members or clients. Each attend with their own concerns and cultural and ethnic backgrounds, and each expect that they will leave with as little aggravation and as much speed as possible. However, in order for this to occur, there has to be a recognition by all that, just as the campus has an obligation to those passing through it to be a safe working and clinical environment with a culture of care and respect to all, so the public passing through it have an obligation to maintain a similar culture of care recognising that no workplace is perfect, that building designs and ageing infrastructures can cause angst, and that staff may be working to programmes and schedules that are difficult to meet and maintain. The following model of culture and caring has been developed recognising that the ultimate workplace is one in which there are no episodes of covert violence, and where each party recognises and accepts that they have a role to play in maintaining such a violence-free workplace. A review of the model on a regular basis by a committee made up of representatives of the parties would be an ideal measure of how genuinely violence-free a particular health campus is, and may offer insights and suggestions into how to deal with any ongoing problems. The model also includes the anticipated outcomes when a health campus does not have incidences of covert violence.

Patients/ Visitors	**Clinical nurses**	**Management**	**Medical practitioners**

1.Know details of own medications and procedure
2.Read any pre-admission information sent out by hospital or doctor
3.Understand that 'first in' is not always 'first seen'
4.Adhere to pre-operational advice given by clinic or doctor
5.Understand that nurses have a number of patients for whom they will need to care
6.Show courtesy to all
7. Be responsible for own behaviour
8. Communicate effectively

1.Ensure safe environment for all persons in facility
2. Show courtesy to all by listening effectively and having a culture of care
3. Be aware of documented doctors' preferences in equipment and medications
4.Be aware of pre-admission notes on patients
5.Liaise with doctors on effectiveness of pre-admission information given out to and by other staff
6. Communicate effectively
7.Provide a peer mentor for all staff including agency nurses

1. Provide strong leadership in displaying culture of care to all staff and clients
2.Provide access for staff and patients to discuss problems
2.Ensure all pamphlets and forms issued to patients are current and easily understood
3.Take reports of covert violence seriously
4. Ensure staff are well educated and well trained in duties
5. Ensure staff are empowered to work efficiently
6. Ensure information about Drs' preferences is available to all staff
7. Institute wellness programmes for staff

1.Give correct admission information to patients
2.Be aware of hospital policies and procedures.
3.Show consideration to all staff and patients
4. Communicate effectively

No covert violence to nurses

Customer satisfaction

Job satisfaction

High standard of health care

Cost effective service delivered

Employee commitment

Minimal employee occupational injuries & sick leave

Good organisation wide communication

Continual improvement in organisational activities

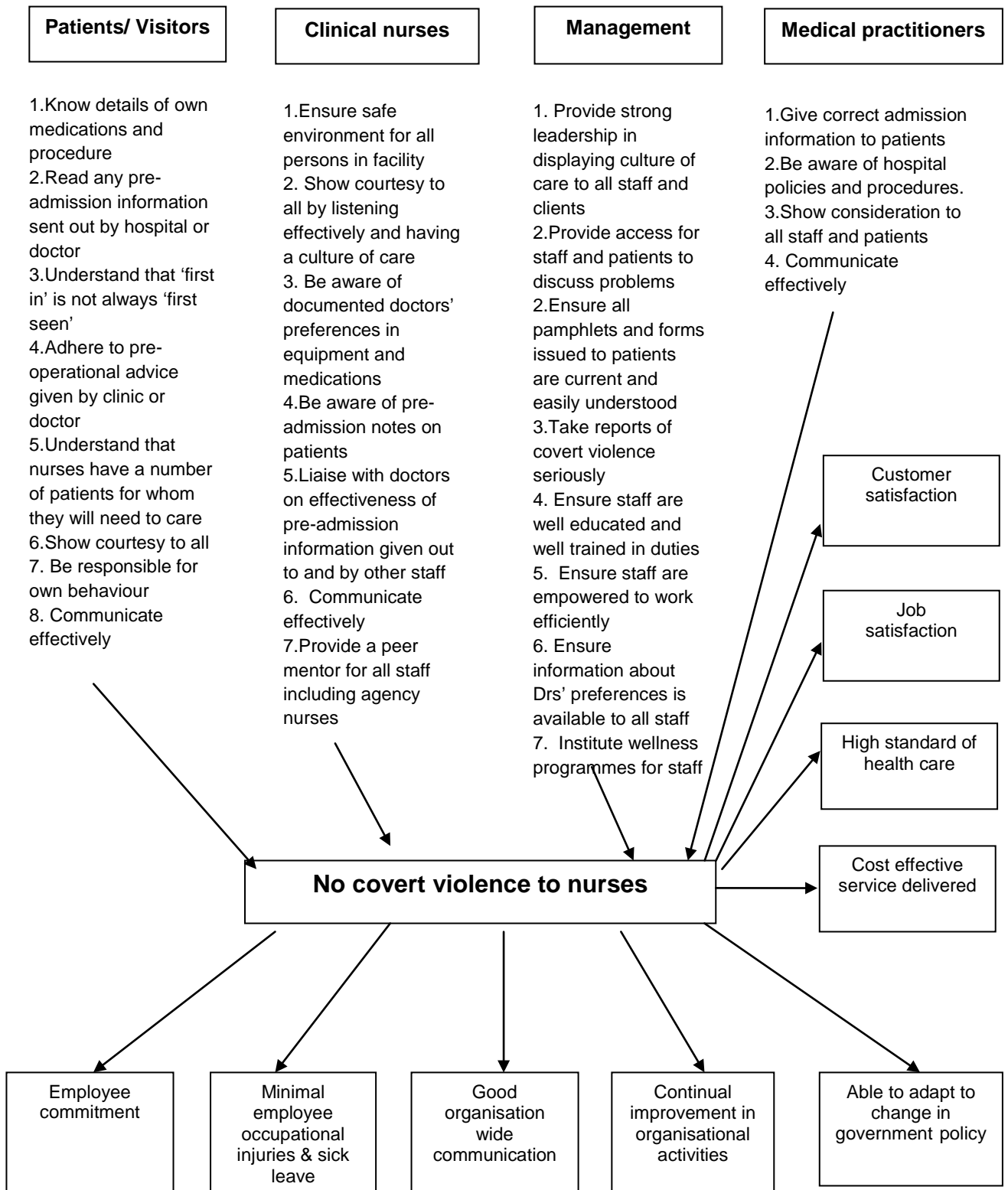Able to adapt to change in government policy

Figure 4 Obligations to prevent covert violence in nursing

6.4. Recommendations for further research

A recommendation from the Pilot Study was to extend that study from one specific health campus to a wider selection of health facilities. This has been achieved in this research. An Australian-wide research study into covert violence in nursing could also be considered.

As well, other studies could include other populations who work in a hospital setting such as ancillary staff including X-ray technicians, pathology personnel and physiotherapists. It could also include 'incidental' care givers such as cleaners, kitchen staff and orderlies.

Further studies could access the direct influence that covert violence has had on nurses and allied personnel who have left the health-care setting.

The Risk Control Action Plan (Appendix D) and the Covert Violence Register (Appendix G) can be adapted for use for other worksites to offer a more cost effective service, a higher customer and staff satisfaction rate, and a means to conduct continual improvement surveys on organisational activities, and to promote greater employee commitment to the organisation. The effectiveness of this tool could be evaluated in terms of reducing the incidences of covert violence. WorkCover W.A. (2010) reported that mental stress accounted for 2.5% of all lost time injuries in the financial year 2008/09, the average mental stress claim was 134 days.

6.5. Research contributions

6.5.1. _Introduction_

This research has identified the characteristics of covert violence experienced by Western Australian nurses and used this information to provide a comprehensive definition of covert violence. It has identified the causes of covert violence towards nurses in a Western

Australian using pattern matching of participants' stories. A comparison between the main study and the Pilot Study has shown that incidences of covert violence continue to rise and, despite all the risk control literature available from both public and government sources, the problem remains.

Following the 2003 Pilot Study there was a move to identify and implement risk control for some forms of violence in the health campuses in Western Australia. At a large city hospital and a small suburban hospital signs were printed declaring violence towards staff would not be tolerated. However, it was mostly physical violence that was targeted and rarely did there appear to be any genuine attempt to remove or censor the perpetrator. Covert violence, as defined in this research study, has not yet been fully recognised as a cause of distress to staff and other patients.

A Risk Control Action Plan has been drawn up as an example so that various intrinsic issues could be used as a template for all health campuses in order to eliminate as many causes of covert violence as possible and practical.

The perpetrators identified in this research came from all categories of users of the health system – patients, nursing staff, medical staff and managers. It was found that all had obligations to each other and to the health campus involved in order to maintain a safe and efficient working environment for all staff. These have been summarised in Figure 4.

For the first time, in an diagrammatical way, figure 4 offer an outline on how each group of people who use a health service (patients, relatives and visitors, clinical nurses, management staff and medical practitioners) have an obligation to ensure that covert violence towards nurses is prevented, to enable a high standard of health care, job and customer satisfaction, lower working costs and minimal employee distress. This could be printed in all the brochures given out to prospective patients, nurses and medical practitioners so that

all are aware of the contribution their behaviour and preparedness will make to the smooth running of the health facility, thereby contributing to better nursing conditions and patient care outcomes.

This research also offers a suggested complaints resolution process outlining stages of resolution for both staff and managers. A suggested workplace violence policy is also offered with the purpose that all employees of a health service should read and understand it, then sign it on employment.

In all Australian Occupational Health and Safety Acts there is a legal requirement that all workers should be offered a safe environment in which to work. It has been shown through this research and other published literature that a health campus free of covert violence results in greater employee commitment, less sick time, continual improvement in patient care, higher employee productivity and a philosophy of care, consideration and courtesy to all people who use the facility.

6.5.2. *What is known about the topic*

Covert violence is evident internationally in many occupations, including nursing, medicine, transport and the military. Current methods for highlighting incidences of covert violence that cause distress are apparently not working. The perpetrators come from both inside and outside nursing.

6.5.3. *What this study adds*

This research study has resulted in the following achievements:

- Critically analysed and reflected on the research results to develop a comprehensive definition of covert violence.

- Critically analysed 287 publications in relation to what was currently known about covert violence to assist with identifying themes for this research and evaluate the relevance of this information in relation to the causes of covert violence in nursing in Western Australia.

- This research has highlighted that covert violence in nursing continues in Western Australia despite there being media releases, posters and government health and safety legislation. Covert violence is still an issue to be addressed by most health service campuses.

- An acknowledgement that between 2003 and 2010 there has been a reported increase in covert violence perpetrated by nursing staff and managers.

- A Risk Control Action Plan (Appendix D) to limit the negative effects of covert violence has been developed. This can be adapted for any workplace.

- Identified the concepts of power and powerless in covert violence and the effect that these have on nurses.

- Identified and critically analysed Australian government legislation (25 Australian Laws and 3 Codes of Practice), government publications and policies in terms of their relevance and implementation effectiveness.

- The development of a Covert violence model policy, (Appendix E) written complaint procedure (Appendix F) and a Covert Violence Register (Appendix G) that could be adapted for use on other worksites.

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8. APPENDICES

APPENDIX A

Letter circulated to elicit participants, and introduction of study.

Opportunity to improve the Occupational Safety and Health of Registered Nurses who work in the Health System

Dear Participant,

I would like to invite you to participate in a study that is being conducted by Edith Cowan University in conjunction with nurses who are employed in the Health Industry in Western Australia. The study aims to identify sources of covert violence that are experienced by nurses in their daily work. For this study, 'covert violence' is defined as 'any non-physical abuse such as a specific behaviour, look, action, humiliating or belittling act that distresses a nurse in the process of her work'.

Little study has been done on this subject in Western Australia. Nurses have been reluctant over the years to report such incidences and when they have, there has been a poor response from Managers. It is anticipated that this research will acknowledge the seriousness of the problem and recommend interventions to prevent or deal with such forms of violence. It is also envisaged that minimising covert violence will result in greater job satisfaction for nurses, reduction in staff absenteeism through job stress, and an improvement in nursing productivity.

As you are a nurse currently working in the Health industry you are invited to be a participant in this study. Such participation is entirely voluntary, and all information gained will be strictly confidential. If

you wish to withdraw at any time, you are able to do so without any penalty or explanation. Participation will involve either

- a telephone interview lasting approximately thirty minutes the details of which will be transcribed and you will be sent a copy by post to check and approve, or

- a written account of some covert violence episodes you have experienced whilst at work, or

- a face-to-face interview, the details of which will be written and you will be given the opportunity to check such details.

This research project has been approved by the Edith Cowan University Research Ethics Committee and is being supervised by Dr Janis Jansz who can be contacted at Edith Cowan University on (08) 6304 5590. For independent advice you may phone the Chairperson of the Ethics Committee at Edith Cowan University on 134328.

 If you would to participate in this study or require further information, please phone me, Susette Bakker on (08) 9294 2776 (H) or (08) 334 3630 (W).

Ssuette Bakker
PhD Student (Health Science, Occupational Health and Safety)
Edith Cowan University

APPENDIX B

Form of disclosure and informed consent for research

I…………………………………… (print name) would like to participate in the study entitled

Covert Violence in Nursing – a Western Australian Perspective.

- I have read and understood the information provided.
- I understand I may withdraw at any time.
- I have been given the opportunity to ask questions and clarify points of interest at any time.
- I understand that no information will be kept that will identify me or my workplace.
- I understand that the information received will be stored according to ECU guidelines, stored in a locked filing cabinet which can only be accessed by the researcher. Data will be held in storage for the required period of 5 years and then will be destroyed by shredding by the researcher.
- I understand that the information provided will only be used for the purpose of the research project and understand how the information is to be used.
- I understand that I am free to withdraw from participation in this research at any time, without penalty or explanation.
- I freely agree to participate in this research project.
- I am aware that I have any questions about this project I can contact Susette Bakker on 92942776 or 93343630.
- I am aware that if I have any concerns about the research project and wish to talk to an independent person, I can contact the Research Ethics Officer at Edith Cowan University on 134328.

I……………………………… (Signature) would like to participate in the study titled Covert Violence in Nursing – A Western Australian Perspective. I can be contacted by the researcher on the following phone number………………………to arrange a suitable time for an interview

APPENDIX C

RESEARCH QUESTIONNAIRE

Please answer the following:

      1. Employment Area – e.g. large/small city/suburban/country

         Hospital/Clinic (private/public), Industrial site.

      2. Gender

      3. Length of time in present position

      4. Length of time in nursing

1. What forms of covert violence have you experienced at your place of work?
2. What caused/contributed to these episodes?
3. How were these episodes dealt with?
4. Did you report these experiences? To whom?
5. What support have you received from management/senior staff?
6. What ideas do you have that may reduce the incidences of covert violence in your workplace?

APPENDIX D

Risk Control Action Plan

As part of the quarterly quality management review for the organization, the work place Occupational Safety and Health (OSH) Manager is to use this risk control action plan, report the findings to the Quality Management Committee, and report to this Committee when risk control measures have been implemented and effectiveness evaluated.

Legend

L = Likelihood   **C - Consequences**

C = Certain   H – High

P = Possible   M = Moderate

R=Rare   L - Low

RR – Risk Rating

E = Extreme. Immediate action required

H = High risk – senior management action required

M = Moderate risk – management responsibility to be specified

L = Low risk – manage by routine procedures

P = Person responsible for action

D – Date action to be completed

Hazard	L	C	RR	Action To be conducted by OSH Manager quarterly or when ever complaints are registered	P	D
Environmental Factors Temperature too hot or too cold Humidity too high	P	M	L	• Use a Heat Stress Monitor to measure temperature and humidity . • Adjust temperature and humidity levels then conduct further tests until staff and patients state that temperature and humidity are satisfactory		
Air movement insufficient or area too draughty	P	M	L	• Monitor user comfort levels.		

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				• Conduct air speed measuring using a Kata thermometer. • Make recommendations for air flow improvements and ensure implementation or improvement. • Have self-closing doors at entry and exit points		
Lighting. Sources of illumination can deteriorate with time, light fittings and windows can collect dust, arrangement of furniture may hinder adequate vision	P	M	L	• Using a Photometer, conduct lighting surveys to measure luminance levels • Conduct a visual assessment of area noting shadows, reflections, glare, cleanliness, flickering globes and general light distribution. • Ask those occupying the room or area about their feelings about the light level. Make adjustments accordingly.		
Crowding of waiting areas	P	M	M	• Ensure seating is sufficiently separated so that each person has, at least, a concept of personal space. • Wherever possible, make a separate area or room available for those in wheelchairs or with prams. • Stagger arrival times for patients.		
Noise	P	M	L	• Interview people in the workplace to determine the level of nuisance noise that may interfere with their concentration at work or their comfort on the wards or units. If any specific problems are identified, make recommendations for noise reduction and ensure implementation.		
Privacy Factors.	P	M	M	• Arrange for pre-admission interviews for all patients, in an office away from other patients and passing staff. • Wherever possible same-sex patients' bedrooms should be instigated.		

				• Separate ablution areas for male and female patients should be ensured. • Some patients to be interviewed by medical staff in office/room rather than at bedside. Limit of 3 visitors per patient at one time.		
Client or Visitor Aggression	P	M	H	• Ensure at least 2 staff on duty in any area at all times. • Increase the efficiency of services provided at peak times to reduce client frustration • Annual security assessment. Install closed circuit television (CCTV) in all interview rooms and waiting areas. • Staff duress alarms should be used, and tested monthly. • All interview rooms to have escape doors and duress alarms fitted. • All incidences of customer and visitor aggression to be reported. • Client records should be coded with details about previous aggressive or violent behaviour • Aggression management training to be given to all staff		
Medical Staff Issues	P	M	L	• Surgical lists to be limited according to an agreed safe pace of work • Adequate nursing staff to be provided to ensure theatres and wards can perform safely and adequately • Medical staff to be made aware of hospital protocols and their updates and additions • Ensure equipment is adequate and acceptable for proposed procedures • Provide regular opportunities for discussions of preferences of medications, equipment		

				and changes to operating procedures with relevant administrative and managerial staff		
				• Workloads of doctors with other campuses to be taken into account when allocating theatre and consultation times		
Management Responsibilities	P	M	L	• Organisation to foster a compassion and consideration for all staff members		
				• Ensure workloads are as equal as possible with no alliance to gender or size of staff member		
				• Secure adequate pool or agency staff to cover holiday rostering or staff illnesses		
				• Ensure enough staff rostered for each area to allow for safe working practices		
				• Expectation of overtime should not be the norm		
				• Staff education to be scheduled out of meal times and covered with adequate staffing. All staff to have equal opportunity to education including night staff		
				• Staff holidays to be fairly distributed		
				• Consult with staff re holiday and leave entitlements and planning		
				• Ensure all staff are made aware of changes in protocols and policies. Include less senior staff on protocol and policy committees		
				• All staff to be made aware of any new budget constraints as soon as possible		
				• Take all reports of incidences of covert violence seriously and responsibly. All staff to have access to hard copies of workplace regulations and Acts that relate to incidences of covert violence in the workplace, or allow all staff computer access to these publications		
				• Liaise with staff, patients and community representatives to establish suitable parking facilities and costs for all users of campus		

APPENDIX E

This could be adapted for a health service.

MODEL WORKPLACE VIOLENCE POLICY

Purpose

The purpose of this policy is to assist in making the workplace violence-free. This policy will assist the organisation to comply with their legal obligations to meet the requirements of occupational health and safety legislation and antidiscrimination legislation.

Application

This policy applies to all staff, clients, contractors and visitors on the business premises.

Definitions

Overt Violence

Overt violence is the intentional use of visible physical force or power, threatened or actual, against another person or persons, that may result in, or has a high likelihood of resulting in injury, psychological harm, deprivation or death.

Covert violence

Covert violence is any act or word that has a negative impact on another's self-esteem, quality of life or ability to perform their allotted tasks.

Policy Statement

The organisation is committed to taking all reasonable steps to maintaining a violence-free environment. This will be achieved by:

- Facilitating a culture of caring through showing care and respect for all people and property;
- Providing adequate resources (including enough time to perform work duties safely) for necessary tasks;
- Establishing a teamwork ethos;

- Promoting a learning environment;
- Monitoring effectiveness of relevant education and employment policies, procedures and practices;
- Establishing adequate and evolving lines of communication with all staff and users of the facility;
- Acting on all reports of violence immediately to facilitate grievance resolution to the eventual satisfaction of all involved where possible.

All people charged with the responsibility of the management of others, be they staff, clients, visitors or contractors are responsible for maintaining a safe, violence-free working environment.

Staff, clients, contractors and visitors shall accept their joint responsibilities and co-operate to maintain a violence-free workplace.

Supporting procedures and legislation
- Model complaint resolution procedures for covert violence.
- List all other relevant workplace procedures related to the policy.
- List all relevant legislation related to this policy.

Responsibilities for policy + procedures

Policy Manager	Position Title
Contact	Phone number
	Fax number
	Email
Approval authority	
Review date	

Revision history

Revision reference number	Approval Rescinded	Date	Approval Committee/ Board	Resolution number	Document reference number
1	Approved				
2	Amended				

APPENDIX F

MODEL COMPLAINT RESOLUTION PROCEDURES FOR COVERT VIOLENCE

Staff Member duties

1. Seek advice from a contact officer, grievance officer, workplace safety and health personnel or from a union representative.

2. Keep a personal record of all incidences involving a perpetrator of covert violence that may contradict that person's accusations against you, e.g. any written information, witnesses and their statements. Avoid being alone with the perpetrator.

3. On advice from contact or grievance officer, approach the perpetrator telling them you are not happy with their behaviour or words.

4. If covert violence behaviour does not cease, report incident/s via Covert Violence Register to senior management.

Management duties

1. Address any report of violence **IMMEDIATELY.**

2. Discuss incident with both victim and perpetrator. Respect each party and promote mediation between parties if appropriate. Confirm acceptable behaviour policy.

3. If behaviour continues, perpetrator may need to be moved or reassigned to work in another area of the organisation.

4. Provide support service to victimised staff member or offer an independent contact if this is preferred.

5. Conduct regular covert violence awareness education campaigns throughout all areas of the health service.

APPENDIX G

<u>Covert Violence Register</u>

Victim (Name) Action Date

	Abuse	Bullying	Harassment
Ask person to stop			
Told another nurse			
Told senior staff			
Filled out incident report form			
Sought help from union			
Transferred to another area			
Took legal action against perpetrator			

Management Action Date

	Abuse	Bullying	Harassment
Action taken. By whom			
No action taken			
Action deferred			

Result Date for Perpetrator (Name)

	Abuse	Bullying	Harassment
None			
Official Warning			
Red Carded			
Police Notified			
Prosecution			

Result Date for Victim (Name)

	Abuse	Bullying	Harassment
None			
Counselling			
Transfer to another ward/unit			
Other support			