✠ **RESEARCH PAPER** ✠

Workplace violence in Queensland, Australia: The results of a comparative study

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Workplace violence in Queensland, Australia: The results of a comparative study

This paper presents the results on workplace violence from a larger study undertaken in 2004. Comparison is made with the results of a similar study undertaken in 2001. The study involved the random sampling of 3000 nurses from the Queensland Nurses' Union's membership in the public (acute hospital and community nursing), private (acute hospital and domiciliary nursing) and aged care (both public and private aged care facilities) sectors. The self-reported results suggest an increase in workplace violence in all three sectors. Although there are differences in the sources of workplace violence across the sectors, the major causes of workplace violence are: clients/patients, visitors/relatives, other nurses, nursing management and medical practitioners. Associations were also found between workplace violence and gender, the designation of the nurse, hours of employment, the age of the nurse, morale and perceptions of workplace safety. Although the majority of nurses reported that policies were in place for the management of workplace violence, these policies were not always adequate.
Key words: morale, nurses, safety, violence, workplace.

INTRODUCTION

In 2001 and 2004, the University of Southern Queensland, in conjunction with the Queensland Nurses' Union (QNU), undertook a study of members of the QNU. The participants were registered nurses (RNs), enrolled

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nurses (ENs) and assistants-in-nursing (AINs). In Queensland, RNs and ENs work is controlled by the regulating authority—the Queensland Nursing Council. ENs must work under the direct or indirect supervision of an RN. AINs (also known as carers, personal assistants) are unregulated care providers. Although the Queensland Nursing Council has no regulatory influence over AINs, their work is directly or indirectly supervised by RNs.

Workplace violence takes many forms such as aggression, harassment, bullying, intimidation and assault. Inconsistencies in definitions and varied terminologies make comparison difficult. This paper uses the same definition of workplace violence outlined in a previous paper by the authors.[1] This is:

Workplace harassment is defined as:

Repeated behaviour, other than behaviour that is sexual harassment, that is directed at an individual worker or group of workers; and is offensive, intimidating, humiliating or threatening; and is unwelcome and unsolicited; and a reasonable person would consider to be offensive, intimidating, humiliating or threatening for the individual worker or group of workers.[2]

An important aspect to this definition, which is in line with other definitions, is 'repeated'—the harassment is not a single incident.[3] Violence has been defined by Steinmetz and Lystadad as:

an act carried out with the intention or perception (of) having the intention of physically hurting another person.[4]

This definition includes all incidents from minor assaults to premeditated murder. For the purpose of this paper, the term 'workplace violence' is taken to be inclusive of these definitions of workplace harassment and violence.

Workplace violence against nurses is reported to be high[5] and increasing.[6] In one study, nurses were at four times higher risk of assault than the general workforce.[7] Nurses' experiences of workplace violence are not limited to Australia; rather this is a recognized international issue.[1,8–11]

It is generally accepted that there might be a direct link between episodes of violence and aggression towards nurses and sick leave, burnout and poor recruitment and retention rates.[8,12,13] Nurses subjected to physical and verbal attacks have stated that it made them miss work[14] or want to resign.[15] In the former study, one senior nurse stated:

Two of my staff nurses have left their jobs and another staff nurse has requested a permanent night post because she won't have to deal with visitors and their families.[14]

Unfortunately, there is a paucity of studies providing reliable numbers on retention and turnover due to workplace aggression, although a study in South Australia reported that 19.6% of resignations were as a result of workplace bullying.[16] Furthermore, a recent Queensland study has linked workplace violence to levels of personal morale, and subsequently retention.[11]

In the UK, Wells and Bowers undertook a systematic literature review on workplace violence, which they noted as an adverse factor in recruitment and retention.[12] They concluded that although research findings were limited and data were very difficult to compare, nurses do appear to have a high level of risk compared with the general workforce and other health-care professionals.

A review of the literature illustrates differences in violence across disciplines and sectors. For example, aside from verbal abuse, higher rates of violence might be found in psychiatric units as well as units catering for those with a disability and the aged.[17] In a study in the USA, it was noted that nurses working in aged care facilities, emergency departments, intensive care and psychiatric units encountered the highest incidence of violence.[13] Similar results were found in a survey of Queensland nurses in 2001 that noted a significant difference in the rate of workplace violence across the aged care (50%), public (47%) and private (29%) sectors.[1]

It has been shown that acts are perpetrated against nurses from a variety of sources, including patients, relatives, management and other nurses, with patients consistently being the highest offenders.[1,9] Bullying and intimidation has been reported as the most common form of violence from other nurses and higher-ranked staff members on nurses.[8,9]

Differences in definition and perception of what constitutes violence, the source of data and methodology used make comparison of incidence difficult and wide variations occur in the literature. Incidences against the nursing workforce exceeding 50% and 90% for physical attacks and verbal abuse in any one year have been reported in Australia.[8,9] In contrast, Wells and Bowers estimated that at least 9.5% of nurses working in general hospitals in the

UK are the subject of violence in any one year.[12] In perhaps the largest recent study of 217 000 National Health Service (NHS) staff in England, physical abuse in the past 12 months by patients, relatives, managers and colleagues was 12%, 3%, 0% and 1%, respectively. Bullying and harassment over the same period was 22%, 17%, 7% and 10%. In total, 15% of staff had been physically abused and 37% verbally abused.[18]

Any violent acts against nurses are unacceptable. So much so that concern about the levels and consequences of workplace violence has resulted in zero tolerance positions taken by organizations and indeed governments. In the UK in 1999, the Government directed all health trusts to reduce their incidence of violence by 30% over a 3-year period. In Queensland, a zero tolerance policy was launched in 2001 by the Minister for Health and in 2005 the reports of Steering Committee were released.[19] Similar initiatives are taking place in other states; for example, Victoria established a Taskforce on Violence in Nursing in 2004 to define violence, review existing practices and develop strategies.

METHOD
Aim of the study

Both the 2001 and 2004 studies aimed to identify the factors impacting upon nursing work and to use the results of the study to inform strategic planning of the QNU.

Research design

This study involved a descriptive, self-report, postal survey of members of the QNU in October 2004.

Sample design

The study involved a postal survey of 30 000 financial members of the QNU in October 2004. A stratified random sampling design was used with a sampling frame restricted to financial members of the QNU. The strata were the three largest employment sectors in Queensland: aged care (non-government and government), public (government acute hospitals and community nursing) and private (non-government acute hospitals and community nursing). To ensure adequate levels of precision in estimating key measures, 1000 nurses from each of the three sectors were invited to participate.

Of the 3000 participants invited to participate in the 2004 study, 1349 responded, representing an overall response rate of 45%. Response rates varied among the sectors (aged care 42%, public 45% and private 48%). Of the 1342 who provided information that allowed their allocation to a sector, 1306 were in paid employment in nursing in Queensland at the time of the study. The respondents were comprised of 172 AINs, 157 ENs and 913 RNs.

Survey instrument

The 2004 survey instrument was based on the survey used in 2001.[1] Only minor changes were incorporated, as the instrument had been validated in 2001 and a comparison of changes in responses between 2001 and 2004 was of particular interest. Piloting of the instrument was unwarranted because the data collection process was unchanged from that used for the 2001 study. Items modified or added to the 2001 questionnaire procedure, however, were pretested by independent experts and potential participants.

Procedure

The survey packages containing the questionnaire, plain language statement, covering letter and reply-paid envelope were posted to participants by the QNU in early October 2004. Two weeks after the initial mail-out, a reminder package was sent to non-respondents. All surveys were coded and the research team were not able to link the codes to individual members of the QNU. Similarly, the QNU was only provided with de-identified data. The only change from the procedure in 2001 was that the questionnaires were designed using the software program Verity Teleform Version 9 (Verity Inc., Sunnydale, California).

Data analysis

Quantitative data were analysed within and across the three sectors using descriptive and inferential statistical tools as appropriate to the scale of measurement involved. Also, the 2001 and 2004 results were compared within each sector. In order to contain the false-positive error rate, only inferences supported at the 1% level of significance were reported except where more than one sector exhibits a similar trend or where there is prior expectation of an effect. In these cases, a 5% level of significance has been invoked. It should be noted that, because the number of nurses in each of the sectors in the QNU database is not proportional to the number of respondents in each sector, measure averaged over the three sectors must be weighted to be valid. The appropriate weights for the 2004 data are: 17.8%, 65.8% and 16.4%, respectively, for the aged care, public and private sectors.

Limitations of the study

The conclusions reported in this paper apply to nurses who are QNU financial members working in the aged care, public and private sectors in Queensland in October 2004. Although the response rate was relatively high for a study of this type, there is still considerable scope for non-response bias in the results. No systematic trends in the time order of receipt of the surveys were apparent in the measures that are the focus of this paper. A comparison on the basis of demographic variables between the respondents and the QNU membership database for each sector found no significant difference in gender balance and job designation. However, respondents were significantly older than non-respondents in each of the three sectors. The impact of this bias on the measures of interest in this paper has been assessed and is insufficient to substantively affect the reported results. Results reported as significant remain significant after allowing for this effect.

Restricting significance to the 1% level with the sample sizes involved in this study means that differences in percentages of less than $\approx 12\%$ between sectors or between years are likely to remain undetected. Hence, the absence of a significant difference does not necessarily the complete absence of a difference.

Ethics

The study was approved by the Human Research and Ethics Committee of the University of Southern Queensland, Toowoomba, Australia.

RESULTS
Levels and sources of workplace violence

The majority of nurses in this study reported experiencing some form of workplace violence in the previous 3 months (see Fig. 1). Not only is there evidence of a highly significant difference in reports of workplace violence across the sectors ($P < 0.001$), but there is also evidence that the incidence of workplace violence has increased in each of the sectors between 2001 and 2004 ($P = 0.02$ aged care, $P < 0.01$ public and $P < 0.001$ private).

Respondents who reported experiencing workplace violence in the previous 3 months were asked to identify the sources of these incidents (see Tables 1, 2).
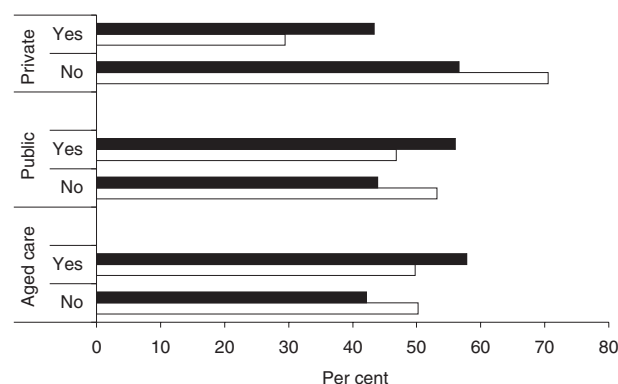

Figure 1. Experience of workplace violence in previous 3 months. □, 2001; ■, 2004.

Table 1 Sources of workplace violence 2004

Source	Aged care		Public		Private	
	N	%	N	%	N	%
Clients/patients	179	75.8	175	74.8	106	54.1
Visitors/relatives	58	24.6	105	44.9	52	26.5
Other nurses	90	38.1	86	36.8	72	36.7
Nursing management	63	26.7	57	24.4	71	36.2
Other management	14	5.9	13	5.6	7	3.6
Doctors	13	5.5	38	16.2	60	30.6
Allied health professionals	6	2.5	6	2.6	4	2.0
Other staff	34	14.4	11	4.7	17	8.7
Others/unknown	7	3.0	10	4.3	0	0.0
Total number of respondents	236		234		196	

Table 2 Sources of workplace violence 2001

Source	Aged care		Public		Private	
	N	%	N	%	N	%
Clients/patients	154	74.8	138	63.0	67	48.6
Visitors/relatives	24	11.7	74	33.8	19	13.8
Other nurses	38	18.4	54	24.7	50	36.2
Nursing management	35	17.0	33	15.1	21	15.2
Other management	20	9.7	15	6.8	10	7.2
Doctors	9	4.4	35	16.0	44	31.9
Allied health professionals	2	1.0	6	2.7	2	1.4
Other staff	9	4.4	7	3.2	7	5.1
Others/unknown	1	0.5	6	2.7	2	1.4
Total number of respondents	206		219		138	

Clients/patients

Very significant differences exist across the sectors in both 2001 and 2004 ($P < 0.001$). In both 2001 and 2004, of those nurses experiencing violence, a lower percentage in the private sector cited the source as clients/patients. Also in 2001, but not in 2004, the percentage within the aged care sector is greater than that within the public sector. In the public sector, there has been a significant increase ($P = 0.001$) in the proportion of reported incidents involving clients or patients between 2001 and 2004.

Visitors/relatives

Highly significant differences exist across the sectors in both 2001 and 2004 ($P < 0.001$). In both 2004 and 2001, the reported rate of incidents involving visitors/relatives was considerably higher in the public sector than in the other two sectors. A significant increase between 2001 and 2004 in the reported rate of incidents involving visitors/relatives has occurred in the aged care ($P < 0.001$), public ($P < 0.01$) and private ($P < 0.01$) sectors.

Other nurses

In 2001, but not in 2004, there were significant differences across the sectors ($P < 0.001$) in the proportion of nurses citing other nurses as a source of violence. In particular in 2001, the proportion in the aged and public sectors was greater than that of the private sector. There has been a significant increase from 2001 to 2004 in the percentage of nurses citing other nurses as a source of inci-

dents in the aged care ($P < 0.001$) and public ($P < 0.01$) sectors.

Nursing management

There is some evidence in 2004 ($P < 0.05$), but not in 2001, of a difference across the sectors in the proportion of nurses citing nursing management as a source of violence. In particular, a higher percentage is associated with the private sector than the other two sectors. In all sectors, there is significant evidence of an increase between 2001 and 2004 in the reported proportion of incidents involving nursing management (aged care $P < 0.01$; public $P = 0.01$; private $P < 0.001$).

Medical practitioners

There is very significant evidence ($P < 0.001$) in both 2004 and 2001 of a difference across the sectors in the proportion of nurses citing medical practitioners as a source of violence. In particular, a higher percentage is associated with the private sector than the public sector, which in turn is higher than the aged care sector. There is no significant evidence of a difference between 2001 and 2004.

Gender

Except for the private sector in 2004, the proportion of male nurses reporting workplace violence is substantially higher than the proportion of female nurses in both 2001 and 2004. In the public sector, the difference is significant (2004 $P < 0.01$; 2001 $P = 0.01$) despite the relatively
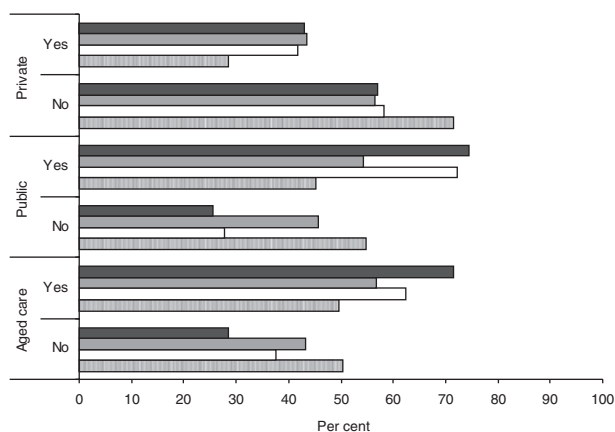
Figure 2. Workplace violence and gender. ■, 2004 male; ▩, 2004 female; □, 2001 male; ▥, 2001 female.

Figure 3. Perceptions of workplace safety and incidences of workplace violence. □, yes; ■, no.

small number of nurses in the survey. In all sectors, the percentage of female nurses reporting workplace violence has increased significantly between 2001 and 2004 (see Fig. 2).

Designation of the nurse and workplace violence

Although power is compromised because of small numbers in some samples, there is evidence to suggest that in 2004, but not in 2001, AINs and ENs in the aged care sector reported more violence than the RNs in this sector. Additionally, ENs ($P < 0.05$) and RNs ($P < 0.001$) have experienced highly significant increases in workplace violence from 2001 to 2004.

Hours of work and workplace violence

Permanent part-time employees in the private sector reported a highly significant increase in workplace violence from 2001 to 2004 ($P < 0.01$). Although not significant, the trend across all work patterns in all sectors is one of increase since 2001.

Age of the nurse and workplace violence

In the aged care sector only, the reported level of workplace violence in 2004 decreased significantly with the age of the nurse ($P < 0.01$).

Workplace safety and workplace violence

In each sector, association between workplace safety and workplace violence exists and is highly significant ($P < 0.01$). In each sector, there is a highly significant ($P < 0.001$) tendency for a poorer perception of work-
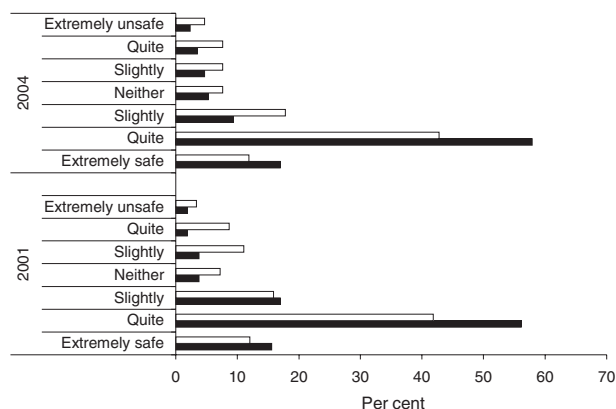
place safety to be associated with a higher incidence of reported violence (see Fig. 3).

Morale and workplace violence

Those who had reported as being subjected to workplace violence in the last 3 months rated workplace morale as being poorer than those who were not subjected to workplace violence ($P < 0.001$). This relationship was evident across all sectors. However, in the aged care sector, those nurses who believed morale was 'extremely poor' (33.5%) were more likely to report being subjected to workplace violence than those in the private (23.5%) or public (19.5%) sectors.

Effectiveness of workplace policies

Nurses were asked whether there was a workplace policy in place for dealing with the workplace violence of other staff and for patients/visitors/relatives. They were also asked to comment on the effectiveness of these policies.

Workplace policy for aggressive behaviour of other staff (defined as nurses, management, doctors and allied health professionals)

Highly significant differences exist among sectors ($P < 0.001$) mainly because of the relatively lower proportion of 'don't knows' of the existence of a policy in the aged care sector (9%) as compared with the other sectors (15% and 18% for public and private, respectively). However, there was a trend for greater awareness in all sectors as the 'don't knows' were reduced.

Also, highly significant changes in responses to this question occur between 2001 and 2004 in each of the sec-

tors because of a drop in the proportion of 'no' responses. Across all sectors, the number of respondents who stated that their institution had no policy had fallen from 10.8% to 4.9% (Fig. 4).

There was also strong evidence of a difference across sectors regarding the perception of the adequacy of the policy. On average, the nurses working in the aged care sector were more likely to believe the policy was adequate and those in the public sector are more likely to believe the policy is inadequate ($P < 0.001$).

Policy for aggressive patients/visitors/clients and the perceived adequacy of the policy

There is a significant difference across sectors ($P < 0.001$) with regard to the knowledge of the existence of a policy regarding aggressive behaviour of patients/clients/visi-
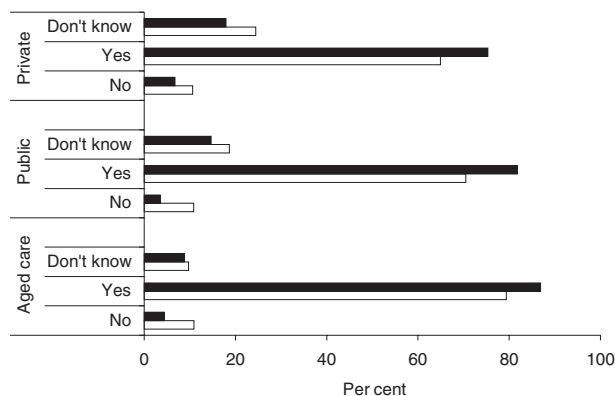

Figure 4. Existence of a workplace policy for aggressive behaviour of other staff. □, 2001; ■, 2004.

tors. This is the case in both 2001 and 2004. The major reason for this difference is the relatively high 'don't know' response rate (27%) in the private sector compared with the public (13.7%) and aged care sectors (16%). The number of respondents who noted the existence of a policy had increased from 2001 to 2004 across all sectors and the number who stated that there was not policy had reduced significantly (Table 3).

With regard to the adequacy of the policy, there were differences evident across the sectors ($P < 0.01$). The main differences are the relatively low proportion of 'sometimes' response in the private sector and relatively low proportion of 'always or nearly always' response in the public sector compared with the other sectors (see Fig. 5).

DISCUSSION

To our knowledge, our data are the first from a follow-up quantitative study. One of the most significant findings of the 2004 study is the high rate of workplace violence and the increase in reports of workplace violence from 2001.

Extent of workplace violence

The extent of reported violence is extremely high when compared with recent overseas surveys. For example, 12% of nurses reported physical abuse from patients and 3% from relatives in a survey of public sector NHS workers that included over 60 000 nurses.[18] In the same study, the proportion of workers noting verbal abuse from patients, relatives, managers and other colleagues was 22%, 17%, 7% and 10%, respectively. Wells and Bowers review of the literature concluded an annual rate of 9.5%

Table 3 Knowledge of workplace policy for aggressive patients/visitors/clients

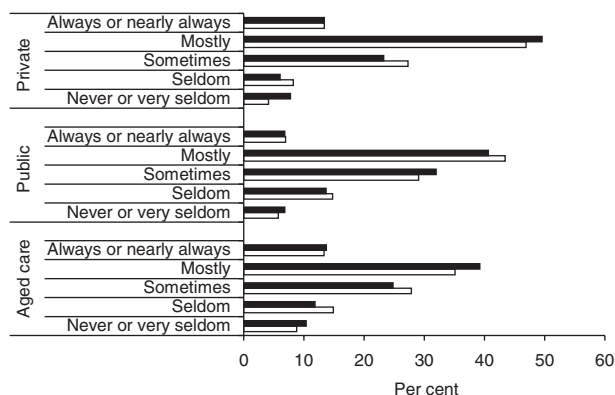| Year	Answer	Aged care		Public		Private	
		N	%	N	%	N	%
2004	No	39	9.40	19	4.50	35	7.70
	Yes	308	74.60	345	81.80	298	65.20
	Don't know	66	16.00	58	13.70	124	27.10
	Total	413	100.00	422	100.00	457	100.00
2001	No	82	19.30	76	15.50	61	12.50
	Yes	303	71.30	315	64.40	270	55.30
	Don't know	40	9.40	98	20.00	157	32.20
	Total	425	100.00	489	100.00	488	100.00

Figure 5. Perceptions of the adequacy of workplace policy for aggressive behaviour of patients/visitors/clients. □, 2001; ■, 2004.

for physical assault and a 'significantly higher' incidence of verbal assault in general nursing.[12] Similarly, in the USA, recent figures of for physical and non-physical violence were 13.2% and 38.8% in a survey of 6000 nurses.[13]

Many violent acts are unreported and small increases in reporting alone might have huge effects. A study of 9000 nurses in Alberta, Canada found that 300 were abused once every five shifts but only 46% reported the violence.[20] In 2004 in England, reporting of incidence by NHS staff was around 68% for physical and 54% for verbal attacks.[18]

A higher proportion (> 50%) of our respondents noted that they have been subject to an act of violence in the last 3 months. Nevertheless, this high frequency of workplace violence is consistent with other studies in Australia[9–11] that have all undertaken surveys within single institutions. Questions have to be asked as to why the Australian figures are high. It is possible that it is due to a different understanding of what constitutes violence. However, the definition in the UK is equally as broad.

Although the literature and these results point to increased violence in the workplace, it is important to exercise some caution in the interpretation of these results. Hollings suggested that violence has not increased, rather people are experiencing an increased level of fear that is damaging any sense of objectivity and perception.[21] Bowie suggests that there might be a number of other reasons for this purported increase, including de-institutionalization of psychiatric patients into the community and societal acceptance of increasing levels of violence as a means to an end.[22]

There are other possible explanations. For example, nurses might be coming more assertive and refusing to accept abuse and violence as a normal and acceptable element of their working environment. When asked about violence, people are more likely to recognize they have been a victim and indicate so on a survey.

Queensland Health has a zero tolerance policy and it should follow that, with increased awareness, more reporting would occur. Furthermore, Queensland Health has defined violence to include physical and psychological harm or injury caused by threats, abuse, intimidating behaviour attacks and assaults including 'intentional physical attacks' and 'sexual harassment'.[19] Therefore, interpretation of our question on violence might have changed from 2001.

Sector differences

It is known that there are violent 'hotspots' (e.g. mental health) for nurses. In our study, we were not able to analyse the data to this level. However, we did compare sectors, and the private sector although reporting a lower overall incidence of workplace violence reported the greatest increase. The sector differences are consistent with our previous study.[1]

Farrell noted that private sector nurses were more concerned about aggressive acts but less inclined to speak out and suggested that the overall lower reported incidence of violence in the private sector might be evidence of job security.[10] Regardless, we believe that it is entirely conceivable that the differences that we found correspond to genuine differences in the level of workplace violence, rather than a reluctance to speak out.

Perpetrators of violence

It is a general assumption that patients are the source of violence to nurses. However, this is clearly not so and other studies have demonstrated this.[10,18] The perpetrators of violence in this study yielded very interesting results for they differ considerably among sectors. Consistent with the previous studies, patients were the highest source of violence in all sectors[1] but were 20% lower in the private sector. The reported level from patients increased in all sectors but the public sector demonstrated by far the highest increase since 2001. It is possible that an explanation of the increase of this source of workplace violence from patients is cost containment. A study in the USA has noted that funding cuts, which resulted in increased waiting lists for admission to hospital, had resulted in increased patient aggression towards nurses.[17] Another US study identified that the principal perpetra-

tors of patient physical and non-physical violence were males > 65 years and males 35–65 years of age, respectively.[13] Further investigation is warranted to determine whether such classifications might be identified here to support pre-emptive action.

Visitors and relatives as the source of workplace violence were reported by at least a quarter of respondents in the private and aged care sectors. Other studies have shown similar results.[10,14] What is of great concern is that the figures have doubled since 2001. Violence by visitors and relatives in the public sector also increased since 2001 and was reported by almost 50% of the respondents. Although no specific studies have provided information, it is possible, as noted for patient/client-sourced violence, that one influence on this change is cost containment.[17] The qualitative data support this theory with some nurses noting that abuse from relatives was linked to the nurse's inability to provide the expected level of care to a patient (because of workload).

Similarly, there was also some indication from respondents in this study that the Privacy guidelines/legislation meant that they were now more contained in the information they could provide to next-of-kin. The nurses believed that lack of information by relatives about restrictions resulting from the change in legislation resulted in an increase of abuse from visitors/relatives.

Nursing management was indicated as the perpetrators of violence by over a third of the respondents. This figure had almost doubled since 2001. In addition, although no pattern emerged from the 2001 data, in 2004 private sector nurses were more likely to identify nursing management as a source (36%—an increase of 15% since 2001). This compares with increases from 15% to 25% for the other two sectors. It might be that the larger workload and shortage of nurses have resulted in increased bullying by senior management towards nurses to 'work harder with less'. Certainly, the qualitative data suggest that this is one factor, and bullying by higher-ranked staff has been reported to be the most common form of workplace violence by other studies.[16]

Other nurses are the second most common source of workplace violence. No sector differences occurred; however, there was a significant increase from 2001 to 2004 (25% to 37%). It is interesting to note that private sector nurses in a Tasmanian study were twice as likely as those from the public sector to report that stress associated with aggression from other colleagues was the most disturbing type of stress.[10]

Violence from medical practitioners in the private sector was higher than in other sectors. Previous studies have noted that a collegial working relationship between medical practitioners and nurses does impact upon the job satisfaction of nurses.[23] Similar to the results in 2001, there is a significant difference across sectors in 2004. In the private sector, respondents are more likely to report workplace violence from medical practitioners (30.6%), compared with 16.2% in the public and a low 5.5% in the aged care sectors. There is no significant change in the percentage of nurses reporting medical practitioners as a source of workplace violence between the 2001 and 2004 studies.

We did not separate the type of violence according to perpetrator. From other studies, it is likely that the incidence of violence by management, colleagues and other staff is mostly of a non-physical nature and this is one area that warrants further study.

Gender differences

In 2004, the proportion of male nurses reporting workplace violence was higher than female nurses in both the public and aged care sectors. In the public sector, despite the small number of male nurses in the survey, the difference is statistically significant. In 2001, male nurses in the private sector were more likely than female nurses to report workplace violence. This difference was no longer apparent in 2004. In all sectors, the percentage of female nurses who stated that they had experienced workplace violence has increased significantly in 2004 and a similar but not significant trend appeared for males.

There is conflicting evidence with regard to workplace violence and gender in previous studies. These include: (i) no statistically significant difference for gender in two UK studies of nurses,[12,24] (ii) more likely to occur in females than males;[25] and (iii) male nurses experiencing more workplace violence than female nurses in Sweden[26] and the USA.[13] No definite explanation can be offered at this time as to why there might be gender effects or why studies yield differing results. However, it is speculated that male nurses might have more exposure to violent patients. This aspect certainly warrants further investigation focusing on the gender of both aggressor and victim, the type of aggression and location.

Job grade and age

There is evidence to suggest that in 2004, but not in 2001, ENs and AINs in the aged care sector (both public and pri-

vate aged care) are more likely to report workplace violence than RNs. This is an expected finding as the ENs and AINs provide the clinical care within this sector with RNs often in a more supervisory role.

Grade and age differences in violence have been reported by various authors with most cases in younger and less experienced student nurses.[12,24,27,28] This age effect is in accordance with our data only for the aged care sector. In that sector, nurses who reported that they had been subject to violence in the last 3 months were nearly 3 years younger than those who reported no violence. No significant age effects were seen in the other sectors although similar trends could be detected.

Workplace safety

In each sector, the perceived degree of workplace safety was inversely related to the incidence of reported workplace violence. This finding is consistent with Spurgeon and Barwell who also found that lowered perceptions of a safe workplace were linked to workplace violence.[29] We did not identify types of violence; however, studies show that physical and verbal are equally damaging.

Workplace morale

Several authors have associated workplace violence with morale.[11] In another recent international study of nurses and verbal abuse in the clinical setting, 92% of respondents reported that verbal abuse negatively affected morale.[30] In our study, those who had been subjected to workplace violence in the last 3 months rated workplace morale as being poorer than those who were not subjected to workplace violence. This relationship was evident and extremely dramatic across all three sectors. The proportion of nurses who indicated that morale in their workplace was positive dropped by at least 20% if they had been subjected to violence.

Workplace policies

Recognition of the adverse effects of workplace violence has resulted in policies and strategies being implemented at levels from government down to individual institutions. We were interested in investigating whether there was a change since 2001 in the number of workplaces with policies and nurses' knowledge about those policies. For each sector, there were fewer 'don't know' responses and less 'no' responses than in 2001 in answer to questions regarding the existence of policies about workplace violence perpetrated by both other staff and patients/clients.

Although we cannot say definitively that more policies exist, it is apparent that awareness of their existence has increased. This finding might reflect activity from institutions, Queensland Health and the QNU over the 3-year period aimed at increasing awareness of workplace violence.

Sector differences did occur, however, suggesting that workplace awareness might be lacking or not consistent. In particular, in the private sector, 18% of nurses were unaware of the existence of staff policies and 27% of nurses were unaware of the existence of patient/client/visitor policies. This finding suggests that this sector really needs to raise the profile of this important issue.

One study revealed that < 10 years ago, 65% of nurses in an Australian teaching hospital did not know about the support mechanisms to assist them to deal with and recover from an aggressive episode.[9] In the UK where a great deal of action has taken place in the last 5 years with respect to workplace violence, 85% of health-care workers (nurses constituted 30% of respondents) had knowledge of reporting policy.[18]

It is interesting that the lack of knowledge about the existence of policy for staff violence and policies for patient/clients/visitors violence differed in both the aged care and private sectors. Although knowledge of the existence or absence of policies was consistent in the public sector, in the other two sectors twice as many staff were unaware of the patient/client/visitor policy as they were of the staff policy. The differences that nurses perceived in adequacy of policies demonstrated between the two source groups could reflect differing management attitudes towards violence from different sources. Nurses in one study perceived senior management's reluctance to recognize visitors' violence towards nurses as a problem.[14] In the same study, nurse believed they were most vulnerable in situations of high workload.

Zero tolerance is not just about preventing violence and raising awareness of its existence. Probably, the most critical issue is to ensure that action is taken. Therefore, we explored what nurses' perceptions were as to the effectiveness of policies against workplace violence.

In the Healthcare Commission survey in England, NHS workers responded 'yes', 'no' or 'don't know' to questions about effective action to reported abuse. The proportion who stated that effective action was not taken was 5% in the case of physical and 11% in the case of verbal abuse.[18] However, the QNU nurses were given a graded scale for their answers; the proportion who stated 'never'

to the adequacy of policy was 8.3% for patient and 12.6% for other workers. It is recognized that one question was related to action and one to policy, but the results do show similar magnitude.

The QNU nurses in the aged care sector were more likely to believe that the policies were 'always or nearly always' effective. In contrast, nurses in the public sector were the least likely to believe that the policy was effective. When compared with the percentage of nurses reporting workplace violence, the results suggest that, although there are policies in place, they are not as effective as they should be. Furthermore, as no differences appeared from 2001 to 2004, concern must be expressed that, despite the development of policies and strategies, actual progress is lagging behind.

Rickers postulated that a reason for increased violence was in management response.[20] Through a Broken Windows theory, it was suggested that lesser criminal acts—such as vandalism—in a community creates an environment where more crime takes place.[20] The same explanation can be applied to hospital settings whereby if coworkers are abusing each other and that is seen as okay, patients are more likely to commit violent acts. Only by taking action against each and all forms of violence will it end.

Many nurses commented on workplace violence. The major themes indicated that nurses associated violence with increased workloads, the lack of understanding by relatives of the Privacy legislation and guidelines, cost containment exercises on the part of the organization and tolerance by management of violent acts from other staff.

Nurses reacted to the experience of aggression in a variety of ways.[9] Whether the response is the taking of sick leave, alcohol or drugs or leaving the profession, none of these actions are conducive to improving medical care.

CONCLUSIONS

The results of the 2001 and 2004 studies have confirmed previous findings of workplace violence as well as provided new evidence of influences on workplace violence not previously reported. One of the major findings is that the sources of workplace violence differ across the three sectors. The results suggest that the context of practice is an important consideration, and that a 'one size fits all' education programme or policy would not be effective to manage these differences.

The studies confirm workplace violence remains an issue within nursing and we would suggest that the issue is increasing in importance in parallel as the data from the 2004 study appear to indicate an increase. Whether this is an increase in actual workplace violence, or an increase in awareness of what workplace violence is, cannot conclusively be stated. The bottom line is, however, that regardless of source or frequency an environment that is considered unsafe is not good for clients, employees or employers.

Some aspects of this study (e.g. gender) require further investigation.

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