



College of Registered Nurses
of Nova Scotia

Position Statement

Violence in the Workplace

Definitions

Abuse: can be emotional, verbal, physical and sexual (College of Nurses of Ontario, 2002).

Boundary spanner: describes occupations and job titles that bridge the gap between organizational members and outsiders such as customer service representatives or registration clerks (Hoobler & Swanberg, 2006).

Bullying: a well-recognized form of abuse resulting from power inequities. Bullying is a distinct form of aggressive behaviour. It has varying grades of intensity, ranging from physical actions to slander and individual isolation. It involves unwanted behaviour that is intimidating, humiliating, offensive and embarrassing. Persistent criticism and personal abuse leads to a gradual eroding sense of self (Speedy, 2006). Bullying is also referred to as ‘mobbing’ in some countries (Davenport, Schwartz, Elliott, 2005).

Physical violence: includes any intentional, injurious act or physical force directed towards another person or facility property (Luck, Jackson & Usher, 2006).

Threat: a written or oral communication that implicitly or explicitly states a wish or intent to damage, injure or kill a target. A threat is a criminal act is intended to inflict harm on a subject. It may serve as an instrumental or expressive function (Dalton & Eracleous, 2006).

Violence: an umbrella term that encompasses a range of behaviours often classified as verbal, sexual, physical or emotional. Terms such as assault, abuse and aggression are used interchangeably (Luck, Jackson & Usher, 2006).

Vulnerable populations: includes those living in poverty, those living with mental illness, and the homeless. These populations may experience extreme stress and frustration, may feel powerless and socially isolated, and may have low self-esteem (Hoobler & Swanberg, 2006).

Workplace: any location, whether permanent or temporary, where an employee performs work-related duty (Farley-Toombs, 2006).

Workplace incivility: low-intensity deviant behaviour with ambiguous intent to harm a target, in violation of workplace norms for mutual respect (Hutton, 2006).

A Definition of Workplace Violence

The Canadian Initiative on Workplace Violence defines workplace violence as:

“Any incident in which a person is abused, threatened, or assaulted in circumstances relating to their work. These behaviours would originate from customers or co-workers at any level of the organization. This definition would include all forms of harassment, bullying, intimidation, physical threats or assaults, robbery and other intrusive behaviours ”
(French & Serman, 2007).

Introduction

Canadian workplaces are not immune to acts of violence that endanger employee safety, erode employee self-

image or hamper workplace productivity. The College of Registered Nurses of Nova Scotia (the College: CRNNS) encourages all organizations to honour principles that can form the basis of policies targeting workplace violence (French & Serman, 2007). As a regulatory body, the College supports registered nurses, employers, and its own employees, in creating and maintaining quality practice environments.

The foundation for a healthy work environment is one in which all staff members have a genuine respect for one another (Schaffner, Stanley & Hough, 2005). In workplaces without respect, individuals may experience or witness behaviours such as physical abuse, verbal abuse, sexual harassment, threats, bullying, and intimidation. These behaviours are classified as workplace violence and are disruptive and demoralizing for victims, witnesses and organizations.

In the healthcare sector, staffing patterns, shift work,

demanding workloads, poor security, and interventions requiring close physical contact place nursing and other health personnel at a greater risk of violence (International Council of Nurses, 2006). At the same time, individuals in health care often tolerate or enable behaviours such as berating, abusive language, and condescending communication between colleagues (Schaffner, Stanley & Hough, 2005; Alexy & Hutchins, 2006).

A growing body of literature recognizes that nurses are profoundly vulnerable to abuse, threats, violence and injury in the workplace, and acknowledges violence as an international epidemic. At the same time, RNs describe experiences of violence and abuse in the workplace as negatively influencing their abilities to provide care in diverse practice settings (Henderson, 2003).

Workplace violence does threaten the delivery of effective patient services, compromises patient safety, and may extend beyond the workplace affecting a victim's family. If quality care is to be provided, nursing personnel must be ensured of safe work environments and respectful treatment.

The International Council of Nurses (ICN, 2006) condemns acts of abuse and violence perpetrated against any person, and states that all forms of abuse and violence against nursing personnel violate nurses' rights to personal dignity, integrity and freedom from harm. The College supports a zero tolerance approach to workplace violence and is committed to helping nurses feel supported, visible and valued by others in our healthcare system.

In Nova Scotia, employers have an obligation to ensure all employees have safe working environments. According to the Nova Scotia Department of Environment & Labour (2007), maintaining safety at work encompasses measuring and reducing the risk of workplace violence.

Who is at Risk for Workplace Violence?

Individuals who work with vulnerable populations, work late hours, and handle money, report the most violence in their workplace. Violence toward healthcare professionals, especially nurses, is common. Those who instigate violence against employees include clients, co-workers and management (Hoobler & Swanberg, 2006).

A report describing violence against public employees in Nova Scotia, including nurses, indicates that intimidation is the most prevalent kind of workplace violence in the public sector. Although actual assaults and property

damage are unusual, one-half of public employees (51%) have been victims of intimidation, threats, or other forms of violence on the job in the past two years (Vector Poll, 2006). Also, 29% of employees report experiencing verbal threats, ridicule, or harassment in the previous two years even though there are policies to deal with violence in the places in which they work (Vector Poll, 2006).

Research shows that the frequency and severity of violent events directed towards nurses is on the rise. Overall, nurses report a higher rate of occupational violence compared to other categories of health care providers and the most common form of violence is verbal abuse followed by threatening behaviour (Luck, Jackson, Usher, 2006). Nurses working in a variety of practice settings have reported being kicked, punched, bitten, bruised, followed after work, threatened with weapons, pushed, thrown to the ground, pulled by the hair, choked, knocked unconscious, and subjected to death threats (Henderson, 2003).

Canadian surveys conducted between 2001 and 2006 found that over 50% of nurses providing direct care had been verbally abused, and 22% reported physical abuse within the previous 12-month period (Henderson, 2003). In Nova Scotia, 32% of nurses reported that patients had physically assaulted them within the past year (Nova Scotia Department of Health, 2006). Results of a member survey conducted by the College in 2006 support these statistics, with the majority of members indicating awareness of and/or experience with at least one form of violence in their workplaces (CRNNS, 2006).

Workplace Incivility

Workplace incivility is distinct from workplace violence in that, in the former, there is an ambiguous intent to harm. Examples of workplace incivility include leaving the copier jammed, using someone's supplies without permission, not sharing information between service teams, and excluding people from unit-based social activities (Hutton, 2006). Incivility creates a culture of rudeness, allowing an attitude of disregard to permeate a workplace. In healthcare settings, incivility has the potential to negatively affect the quality of patient care (Peck, 2006).

Once there is a targeted individual or a clear intent to harm, workplace incivility becomes workplace violence (Hutton, 2006).

Workplace Violence

Workplace violence includes both visible and invisible

actions, and can be pervasive throughout any organization.

Threats

Studies by Dalton & Eracleous (2006) show a high prevalence of threats against hospital workers. Health workers in both inpatient and outpatient settings report frequent threats from patients and note that verbal threats lead to a high proportion of reported assaults. In addition, the anticipation of threats against health workers can undermine patient/staff relationships and lead to lowered standards of care. Subsequently, the College maintains that threats should never be ignored and responses to threats should be immediate and proactive.

Violence in Health Care

Examples of workplace violence, as cited in healthcare literature, include:

- gang violence and criminal intent (e.g., stealing drugs) in the hospital setting
- a patient or family member becoming violent
- employees or past employees using intimidation, bullying, verbal abuse and/or emotional/psychological abuse
- domestic violence spilling over into the workplace (Alexy & Hutchins, 2006).

In addition, registered nurses report having either observed or experienced:

- physical intimidation and violence, including extreme behaviour such as throwing objects, pushing other workers, tantrums, and yelling directly in another person's face
- unpleasant and abusive behaviour, including demeaning others with humiliating or sarcastic remarks and using veiled actions and statements to undermine co-workers professionally
- refusal to cooperate, including refusing to follow directives, cooperate with group decisions, or accept input (Joint Commission Resources, 2006).

Bullying

The most concerning form of aggression experienced by nurses is bullying: abusive group behaviour that seeks to exclude, punish, and humiliate victims in order to drive them from the workplace. Registered nurses in Nova Scotia frequently report this type of violence.

In bullying, a dominant group (individual) excludes individuals who are not accepted, thus increasing their discomfort and propensity to leave (Speedy, 2006).

Bullying is prevalent in workplaces and can result in damaging consequences for both individuals and organizations (Hutton, 2006; Speedy, 2006; Hutchinson, Jackson, et al, 2006). In fact, bullying has become one method of socializing nurses to the workplace and has become an accepted part of the indoctrination process. New nursing graduates are often the victims of this abusive group behaviour.

Bullies are fueled by a desire to hurt, and enjoy perpetuating destructive, repetitive behaviour; seeking to change how individuals think about themselves by eroding self-image, destroying self-confidence and shattering personal values (Speedy, 2006; Hutchinson, Jackson, et al, 2006).

Bullying is described as unrelenting and calculated, causing psychological harm, physical illness and, for some, the eventual inability to work (Hutchinson, Jackson, Vickers, & Wilkes, 2006). Bullying behaviours are overwhelmingly destructive, with an array of, often, subtle actions that are intensely harmful and accumulate over time.

Condoning bullying in any way raises the likelihood that nurses who are victims will be unable to effectively contribute to their organization and are likely to leave the profession altogether (Speedy, 2006). Those in authority who ignore or minimize bullying behaviours often trivialize victims' experiences, thus reinforcing self-doubt and self-blame and allowing the abuse to escalate (Hutchinson, Jackson, Vickers, & Wilkes, 2006).

Knowing these bullying behaviours are being observed and/or experienced in the workplace, the College questions the adequacy of current 'zero-tolerance' policies in responding to bullying within healthcare organizations in Nova Scotia. Although the policies may be adequate, implementation and/or enforcement of the policies may be lacking.

Recognizing that bullying can lead to long-term psychological trauma, and that the impact of psychological violence can be as great as, if not greater than, physical violence and more widespread, the College concurs with the ICN (2006) in its belief that bullying is a serious workplace issue for nurses and that organizations must eradicate this unhealthy and damaging behaviour.

Additional Factors that Put Workplaces at Risk for Violence

Physical and emotional stressors are generally presumed to contribute to acts of violence in hospital settings, and may be aggravated by impatience, misunderstanding, inaccurate perceptions or intolerance directed toward the health facility or the nurse (Luck, Jackson, & Usher, 2006). The presence of illness often causes stress in patients, families and personnel and may aggravate factors that lead to violence (ICN, 2006). For example, cognitive impairment and aversive stimuli can be precipitating factors for violence. In addition, individuals with problematic substance use, mental illness, dementia, acquired brain injury, or patients who are disoriented due to medication or anesthesia may react in atypical ways (Luck, Jackson, & Usher, 2006).

An issue of concern for the College is nurses' individual subjectivity and desensitization to the fact that violence is 'part of the job'. Because of this desensitization, some nurses may be tolerant of violence. However, younger and less experienced staff members do not consider violence 'part of the job' and are more willing to report it (Luck, Jackson, & Usher, 2006).

Since violence is increasing for those providing direct care, every registered nurse must be educated and prepared to use current violence management strategies (Luck, Jackson, & Usher, 2006). Although not reporting incidents of violence may reflect the nursing ethic of putting patients first, it is in the best interest of patients for nurses to report all incidents. The knowledge generated by reporting can minimize further episodes of conflict and reduce the opportunity for, or severity of, incidents in the future (Ferns, 2006).

There are many common risk factors that can put a workplace at risk, including:

- lack of staff training and policies to prevent and manage escalating hostile and assault-related behaviour
- unrestricted movement of the public
- low staffing levels during times of increased activity
- working alone
- working as a 'boundary spanner'
- overcrowded, uncomfortable waiting rooms
- distraught family members
- long waits for service
- poor environmental design (e.g., poorly lit corridors, rooms, parking lots)

- working directly with people, if under the influence of drugs or alcohol
- easy access to drugs or money in hospitals, clinics and pharmacies
- increased use of hospitals by police and the criminal justice system, for criminal holds and the care of violent individuals
- increasing presence of gang members
- prevalence of handguns and other weapons among patients, families or friends (Hutchinson, Jackson, Vickers, & Wilkes, 2006)

In addition, in some organizations it is not uncommon for stressors created by authoritarian managers, negative personalities and work overload to easily translate into workplace violence risk factors (Hoobler & Swanberg, 2006).

Costs of Workplace Violence

The human cost of violence in workplaces is well documented in the literature, and has both short- and long-term effects for employees. Bullied workers leave their jobs at a rate of 25% and are at risk of post-traumatic stress disorder, premature death, suicide, homicide, heavier smoking, excessive drinking, drugs, overeating and loss of relationships (Speedy, 2006). Victims who suffer post-traumatic stress disorder can take four to five years to recover, and some never do (Henderson, 2003). In addition, the impact of bullying on witnesses creates a 'ripple effect' of workplace violence, including reactions such as feeling sorry for the victim, worrying about becoming a victim, being fearful of taking action, and changing jobs to avoid the problem (Speedy, 2006).

In Canada, it is recognized that nurses have one of the highest rates of sick time usage among healthcare professionals. Organizations report that bullying behaviours result in a high rate of absenteeism, lowered morale, loss of productivity, increased staff turnover, increased sick leave, additional recruitment costs, payouts and legal fees. One worrying trend is that the impact of bullying behaviours is resulting in nurses leaving the profession at a time when healthcare is facing a dire nursing shortage (Hutchinson, Jackson, Vickers, & Wilkes, 2006; Henderson, 2003; Hoobler & Swanberg, 2006).

Additional costs to employers may relate to restoring property, extending psychological care for employees, heightening security, and repairing a battered public image. In Nova Scotia, data available from the Worker's Compensation Board indicates that the total claim costs since 2002, for acts of violence in the workplace, was

a total of \$2,001,370. However, researchers agree that the claims data is an underestimation of the number of workplace violence incidents (NS Department of Environment & Labour, 2006).

Addressing Workplace Violence

The College believes that eradicating workplace violence demands courage in naming the problem and a willingness to take action. A new vision for workplace relationships includes changes at the organizational level, with more attention to interpersonal relationships, collegiality, collaboration, mutual respect, trust, commitment to each other, and honesty (Speedy, 2006). The College recognizes that workplace violence is a very complex issue and encourages the following stakeholders, within their respective mandates, to work together in identifying and eliminating all forms of violence in the workplace:

Provincial Government

The provincial government has a role in defining policies that support organizations in the development of enforceable zero-tolerance workplace violence policies.

Canadian Nurses Association

The ICN (2006) urges national nursing associations such as the Canadian Nurses Association to actively sensitize the public and the nursing community to the various types of violence against registered nurses, and to advocate for improved education and ongoing training in the recognition and management of workplace violence.

Regulatory Bodies

The regulatory bodies for health professionals in Nova Scotia should collaborate with stakeholders and each other in defining safe working environments that incorporate enforceable zero-tolerance workplace violence policies. In addition, regulatory bodies should ensure that their members are aware of and have access to current resources on workplace violence.

Unions

Unions should examine collective agreements to ensure that employer policies reflect zero-tolerance to all forms of workplace violence.

Employers

Organizational cultures that foster mutual respect, trust and open communications can help reduce the threat of violence and provide employees with strategies for dealing with problems and issues as they arise. All workplaces should have policies and programs in place designed to prevent workplace violence (Hoobler & Swanberg, 2006).

Human resources' violence prevention policies should focus on both employees and customers, since outsiders perpetrate the majority of verbal and physical violence (Hoobler & Swanberg, 2006). It is the responsibility of senior management in organizations to review and update current policies and implement strategies to stop bullying in the workplace. Efforts to eliminate workplace violence must be organization-wide, support incident reporting, and instill confidence that follow-ups will occur (Schaffner, Stanley, & Hough, 2005). In Canada, the judicial system is making it increasingly clear that it is the employers' duty to protect employees from workplace violence in ways that are similar to proper health and safety measures (French & Serman, 2007).

Registered Nurses

Registered nurses must take action to prevent and stop abuse, and must not accept abuse as 'part of the job' (CNO, 2002). Every registered nurse has a personal responsibility to report and effectively intervene when incidents of violence occur in the workplace (ICN, 2006). RNs need to speak out about violence to help the public understand that these behaviours will not be tolerated (Shaw, 2006). All RNs must reflect on their own behaviours at work to ensure that they are not contributing to a culture of violence in the workplace. Workplaces that foster mutual respect make everyone accountable for their actions and have strategies in place for resolving conflicts (CNO, 2002). The challenge is to change the culture and attitudes of the nursing profession towards violence and aggression so that reporting incidents become the norm rather than under-reporting, which hampers the development and implementation of effective strategies to reduce violence (Ferns, 2006; ICN, 2006).

Conclusion

Workplace violence is a complex issue and can be pervasive throughout an organization (Schaffner, Stanley, & Hough, 2005). The first step in implementing change is to define workplace violence; clearly identifying the victim, types of aggressors and unacceptable behaviours. Organizations must develop or re-examine policies that protect employees from all forms of workplace violence (French & Serman, 2007).

It is evident from the literature that workplace violence results in considerable personal and organizational costs and is a significant concern for all employers and employees (Alexy & Hutchins, 2006). There is agreement that registered nurses are exposed to unacceptable levels of violence in the workplace, and these levels are increasing and have become a major international occupational

health problem (Luck, Jackson, Usher, 2006; Alexy & Hutchins, 2006).

Clearly, if nurses are to support others they must feel supported and safe themselves. In all clinical settings, nursing leadership needs to insist that administrators adopt, monitor and evaluate the effectiveness of zero-tolerance policies toward violence in order to protect nurses, other workers and the general public (Henderson, 2003). A coherent nursing voice needs to be heard in the clinical setting — at the organizational level, as well as at the nursing and public policy level. In Nova Scotia, government, regulatory bodies, unions, employers and employees with a focus on nursing, need to link with the research and develop new ways of discussing and dealing with the ongoing problem of violence in the workplace.

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