

No More Violence

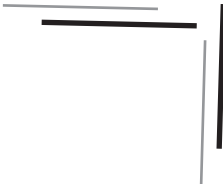


Moving Towards a Violence Free Workplace in Health Care

A Resource



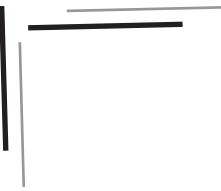
College of Registered Nurses of Nova Scotia



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Welcome

The College of Registered Nurses of Nova Scotia (the College) serves and protects the public interest, preserves the integrity of the nursing profession and maintains public confidence in the ability of the nursing profession to regulate itself. In keeping with the College’s mandate, and recognizing that members of the College continue to report violent experiences in the workplace, a revised version of the Violence in the Workplace position statement has been developed and is available on the College website (www.crnns.ca).

This self-learning resource, which supports the College’s position statement, includes indepth information based on current workplace and nursing literature, as well as feedback from members. It is designed to assist registered nurses recognize specific types of violence, and to consider the use of individual and organizational strategies for eliminating violence in the workplace.

The goal of this resource is to provide accessible information for registered nurses and, if applicable, other stakeholders, as a means of assisting employees and employers in the complex task of eliminating violence in the workplace. The purpose of the resource is to inform registered nurses of the different facets of violence in the workplace, in order to move forward with positive change.

It is anticipated that after utilizing this resource, participants will begin a process to eliminate violence within their organizations. This resource is modular in format and addresses topics such as: facts about workplace violence; risks of experiencing workplace violence; types of workplace violence; and strategies to eliminate workplace violence.

A Word About Self-Learning

The concept of self-learning is grounded in adult education theory and has been utilized by individuals for many years. We all learn differently and have a preferred style when learning new information. If you know what you need to learn and enjoy being independent in your learning then the use of this resource will be a satisfying experience and contribute to your acquisition of new knowledge.

The information modules are self-contained and can be completed in any order based on your individual learning needs. Activities for learning are placed throughout the modules (answers located in the Appendix).

Please take a few minutes and jot down your specific learning objectives:

To begin, choose the modules that best meet your needs.

Please proceed ...

Introduction

In Nova Scotia, employers have an obligation to ensure all employees have a safe working environment (Nova Scotia Department of Environment & Labour, 2007). In addition, everyone has a responsibility, both individually and collectively, to ensure that work environments are violence free. In the healthcare sector the expectation is that management, staff, physicians, patients/residents, family members, members of the public, customers and suppliers ensure that work environments remains violence free.

It is recognized that eliminating violence in the workplace is a complex process, requiring the courage of many to change organizational culture. Effective change begins with increasing awareness within an organization, educating those who provide services or who use services offered by the organization, and implementing organization-wide strategies to create a violence free workplace.



Module 1 - Facts about Workplace Violence



Objectives for Module 1

Upon completion of this module, you will be able to:

- 1) identify the foundation for a healthy work environment
- 2) name three initiatives that can be accomplished organization-wide to create a safe work environment
- 3) define what constitutes violence in the workplace
- 4) state who is at risk for violence in the workplace
- 5) review statistics related to violence in the workplace over the last 10 years
- 6) describe the difference between workplace incivility and workplace violence
- 7) list at least six causes for workplace violence in health care
- 8) choose specific causes that have led to violent behaviour in your workplace
- 9) select the costs of workplace violence that were most surprising to you
- 10) determine if the human and fiscal costs of workplace violence apply in your workplace
- 11) complete learning activity with 100% accuracy.

Time for Change

The foundation for a healthy work environment is one that is free of violence and where all staff members have a genuine respect for one another. To achieve this end, the healthcare sector in Nova Scotia is focusing on creating and maintaining healthy work environments. Success with this initiative can positively impact the existing shortage of nurses and other healthcare professionals by influencing their decision to remain within the province.

By raising awareness, educating people and implementing strategies to create a violence free workplace, individuals and organizations can work together in creating and maintaining a safe work environment (Koster, 2007). It is unacceptable for healthcare providers to tolerate or enable damaging behaviours such as abusive language, condescending communication, witnessing or experiencing verbal abuse, physical abuse, threats and threatening behaviour from anyone including patients/residents, families and friends (Luck, Jackson & Usher, 2006).

In Canada, the judicial system is making it increasingly clear that it is the employer's duty to protect employees from workplace violence no matter who the perpetrator is (French & Serman, 2007).

The issue of workplace violence is complex, making the task of defining it difficult. Workplace violence can be pervasive throughout an organization, and includes visible or hidden activities. Many terms are used to describe violent behaviour including aggression, horizontal violence, bullying, intimidation, harassment, physical assault, emotional/psychological abuse, theft, isolation, exclusion and demeaning actions (Alexy, Hutchins, 2006). (Schaffner, Stanley, Hough, 2005). REMEMBER any of these behaviours are classified as violence because there is a victim (Alexy, Hutchins, 2006).

The Occupational Health and Safety (OHS) legislation in Nova Scotia does not have a definition for workplace violence. However, operationally, the OHS Division uses the following definition found in the Violence in the Workplace Regulations:

“...the attempted, threatened or actual conduct of a person that endangers the health or safety of an employee, including any threatening statement or threatening behaviour that gives an employee reasonable cause to believe that the employee is at risk of injury” (Nova Scotia Department of Environment & Labour, 2006).

Regrettably, the above definition is too broad to be useful in identifying violent behaviours or naming potential perpetrators.

Definition(s):

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).

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

Workplace: any location, whether permanent or temporary, where an employee performs work-related duties (Farley-Toombs, 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 doesn't matter who you are, everyone is fair game for receiving unwanted behaviour that is intimidating, humiliating, offensive and embarrassing. Persistent criticism and personal abuse leads to a gradual eroding of sense of self (Speedy, 2006). Bullying is also referred to as 'mobbing' in some countries (Davenport, Schwartz, Elliott, 2005).

Harassment: any unwanted physical or verbal conduct that offends or humiliates. Such conduct can interfere with one's ability to do a job or obtain a service. It can create a negative or hostile work environment that can interfere with job performance and result in being refused a job, a promotion or a training opportunity (Koster, 2007).

Intimidation: to frighten or overawe especially to subdue or influence (Bisset, A. (Ed.), 2000).

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 and is intended to inflict harm on a subject. It is a specific statement of intent to harm specific staff and is also a specific non-verbal, non-specific verbal, non-interpersonal act meant to frighten specific staff (Dalton & Eracleous, 2006).

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).

This definition is much more specific because it includes more than physical acts of aggression and names the identity of an aggressor.

Learning Activity: 1

(Answers can be found in Appendix, p. 71)

Question:

1. What is the foundation for a healthy work environment?

Your answer: _____

Question:

2. What three organization-wide initiatives can create a safe work environment?

Your answer:

- a. _____
- b. _____
- c. _____

Question:

3. What behaviours constitute violence in the workplace?

Your answer: _____

Question:

4. Reflect on your own experience(s) with violence in the workplace. Which definition captures your experience(s)? Why?

Your answer: _____

Workplace Violence on the Rise

Globally, the frequency and severity of violence in the workplace is increasing – in particular violence towards nurses. Those who instigate violence against employees include clients, co-workers and management. Individuals who work with vulnerable populations, work late hours, and handle money, report the most violence in their workplaces (Hoobler & Swanberg, 2006).

In health care, nurses report a higher rate of occupational violence as compared to other categories of healthcare providers. The most common form of violence is verbal abuse followed by threatening behaviour (Luck, Jackson, Usher, 2006). In addition nurses working in a variety of practice settings also report acts of physical assault (Henderson, 2003).

The following statistics indicate the degree to which nurses and other healthcare providers experience violence in the workplace, suggesting that new ways are needed to address this phenomenon.

International Statistics

In the last decade, international statistics indicate 1:3 nurses left a position because of bullying. New graduates are particularly vulnerable to bullying, with 60% of new grads leaving their first nursing position within six months (Schaffner, Stanley, Hough, 2005).

Internationally, nurses also experience violence at a rate 16 times higher than other professionals. The International Council of Nurses reports that nurses don't feel adequately protected from assaults at work (Shaw, 2006). Work-related violence against nurses is a major international occupational health problem.

United States

Although homicide is the second leading cause of work-related fatalities for women, and 29% of occupational fatalities experienced by women are the result of assaults and violent acts, the majority of workplace violence comprises non-fatal assaults (nearly 2 million per year in the US). (Alexy, Hutchins, 2006).

In a 2004 study, a poll of nurses, pharmacists and other healthcare providers found 90% had experienced some form of workplace intimidation during the past year (Schaffner, Stanley, Hough, 2005).

Definition(s):

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

Another study suggests hospital employees are more likely to be assaulted on the job than employees in other industries (i.e., 8.3 assaults for every 10,000 hospital employees versus two per every 10,000 employees in other private sector industries). In 2000, 48% of all non-fatal workplace injuries from assault or violent act occurred in a healthcare or social services setting (Runy, 2006).

United Kingdom

In England, the Royal College of Nurses reports that 79% of acute and emergency nurses have reported being victims of violent assault in the previous 12 months. The motive for these attacks seems to have been based on the length of time people had to wait in the emergency department. In addition, hospital unit and home care nurses report similar attacks (Donnelly, 2006).

Canada

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 a previous 12-month period (Henderson, 2003).

Nova Scotia

Closer to home, 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, just over 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 reported experiencing verbal threats, ridicule, or harassment within the previous two years even though there are policies to deal with violence in the places in which they work (Vector Poll, 2006).

In Nova Scotia, 32% of nurses reported they had been physically assaulted by patients 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).



Learning Activity: 2

(Answers can be found in Appendix, p. 71)

Question:

1. Who is at risk for experiencing violence in the workplace?

Your answer: _____

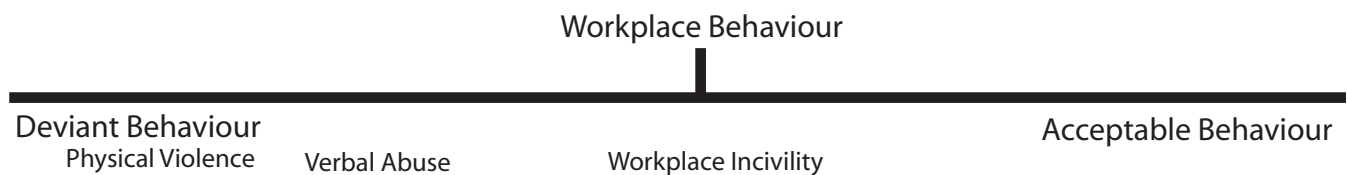
Question:

2. Review the workplace violence statistics. Are any statistics surprising for you? Why?

Your answer: _____

Continuum of Workplace Behaviour

A continuum of behaviour exists in workplaces. Acceptable behaviour is located on the positive half of the continuum and deviant behaviour is located on the negative half. Deviant workplace behaviour is further divided into workplace incivility, and verbal and physical violence.



Workplace Incivility

Workplace incivility is distinct from workplace violence in that the intent to harm is ambiguous in the former. Examples of workplace incivility include leaving the copier jammed without attempting to fix it, using someone's supplies without permission, not sharing information between service teams, and excluding people from unit-based social activities (Hutton, 2006).

Definition(s):

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

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

Workplace incivility is present in both urban and rural areas. There is no relationship between gender and civility. However, there is a collateral effect for employees who report incivility to managers. These employees experience an increased level of retaliatory incivility from co-workers including managers who were not initially involved, and this collateral damage leads to a toxic work environment (Hutton, 2006).

Peck (2006), a senior administrator in health care, notes that from a healthcare perspective incivility creates a culture of rudeness, permeates the workplace with an attitude of disregard, and likely affects the quality of care provided to patients. Understanding more about incivility can assist managers in developing intervention strategies to stop deviant behaviours and intervene early in the incivility spiral — recognizing that there are potential long-term consequences of incivility for both individuals and the environments in which they work. Workplace incivility may initiate a spiral that results in death for one thousand people a year. Addressing this behaviour early is key to reducing violence in the workplace (Hutton, 2006).

In summary, research indicates that incivility pervades workplace environments regardless of the setting, and employees expect managers to intervene and stop the behaviour. The collateral damage from workplace incivility causes an organization to become toxic, resulting in significant psychological and monetary costs for the organization (Hutton, 2006).

It is important to note that once there is a targeted individual or a clear intent to harm, workplace incivility becomes workplace violence (Hutton, 2006).

Learning Activity: 3

(Answers can be found in Appendix, p. 71)

Question:

1. What is the difference between workplace incivility and workplace violence?

Your answer: _____

Question:

2. When learning about workplace incivility, list any facts that are concerning for you.

Your answer: _____

Why? _____



Causes of Workplace Violence

Organizations are becoming increasingly concerned about their “zero tolerance” to violence strategies, especially since there is little written that indicates these policies are effective in keeping employees safe (Dalton, Eracleous, 2006).

It is worrisome that the healthcare sector is organized in such a way that staffing patterns, shift work, demanding workloads, poor security, and interventions requiring close physical contact result in nursing and other health personnel being placed at a greater risk for violence (International Council of Nurses, 2006).

Organizations with cultures that support behaviours of violence play a role in encouraging workplace violence because individuals tend to learn violent behaviours from others. People then become attached and accustomed to these recurring patterns of behaviours and if they become the norm then some individuals may believe that aggression is just “part of the job”(Hoobler, & Swanberg, 2006).

It is worrisome to see overwhelming evidence that nurses do rationalize episodes of violence occurring within their practice environment. For example, some nurses accept a certain level of violence if they view it as being outside the client’s control (e.g., client suffering from hypoxia). Interestingly, younger less-experienced staff do not consider violence ‘part of the job’ and are more willing to report it (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 in behavioural therapy 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).

Other causes of workplace violence include:

- psychosocial and socioeconomic influences, including homelessness, financial burdens, criminal activities, anxiety, domestic disputes and increased intolerance to frustrations (Luck, Jackson, Usher, 2006).
- personally stressful issues such as death, grief, divorce and being a victim of violence are examples of emotionally stressful circumstances. They can be made worse by impatience, misunderstanding, inaccurate perceptions or intolerance directed toward a health facility or nurse (Luck, Jackson, Usher, 2006).

Not all nursing staff are uniformly at risk for aggression. Being a victim of violence can be related to an individual position and role in the healthcare system or a consequence of a nursing philosophy such as continuity of care that allows the same nursing staff to be exposed to patient, family and friends. Interpersonal variables such as specific occupations, number of years of experience, education level, relationship to a perpetrator of violence and work location are shown to have effects on the frequency of episodes of violence (Luck, Jackson, Usher, 2006).

Nevertheless, the risk of violence has increased for those in direct care, and is heavily influenced by an individual nurse's violence management strategies. Therefore, nurses are strongly advised to take evasive, and preventative measures when faced with situations of violence (Luck, Jackson, Usher, 2006).

Learning Activity: 4

(Answers can be found in Appendix, p. 71)

Question:

1. List six causes of workplace violence in health care.

Your answer: _____

Question:

2. What specific causes have led to violent behaviour in your workplace? Please discuss.

Your answer: _____

Costs of Workplace Violence

The human cost of violence in the workplace is well documented in the literature, and has both short- and long-term effects for employees.

For instance, Speedy (2006) notes that 25% of bullied individuals leave their jobs and are at risk of post-traumatic stress disorder, premature death, suicide, homicide, depression, heavier smoking, excessive drinking, drugs, overeating and loss of relationships. These workers also report losing their self-confidence, self-esteem, and belief in their competency, and feel demeaned, inadequate, helpless and physically ill.

According to Henderson (2003), victims who suffer post-traumatic stress disorder can take four to five years to recover, and some never do. In addition, the impact of bullying on witnesses creates a 'ripple effect' of workplace violence, including feeling sorry for the victim, worrying about becoming a victim, being fearful of taking action, and changing jobs to avoid the problem (Speedy, 2006).

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; and Hoobler & Swanberg, 2006). In Canada, nurses have one of the highest rates of sick time usage among healthcare professionals.

Additional costs to employers may relate to restoring property, extending psychological care for employees, heightening security, or repairing a battered public image. In Nova Scotia, data available from the Worker's Compensation Board indicates that the total claim costs between 2002 and 2006, for acts of violence in the workplace, was more than \$2 million. However, researchers agree that the claims data is an underestimation of the true number of workplace violence incidents (NS Department of Environment & Labour, 2006).

Although no figures are available for Canada, the financial cost of workplace violence is staggering in the United States. On-the-job violence costs organizations approximately \$200 billion a year (including awards from litigation). This translates into millions of lost workdays and tens of millions of dollars in lost wages annually (Hoobler & Swanberg, 2006). The cost for each person subjected to bullying is estimated at \$30,000 – \$100,000 due to loss of

productivity and the need for organizational members to intervene. A subtle but long-lasting effect is the reinforcement of a fear-based culture (Speedy, 2006).

In Australia, workplace bullying is estimated at costing businesses as much as \$13 billion a year. For non-litigated cases, the average cost of bullying is \$20 thousand, when litigation is pursued the costs are higher (Speedy, 2006).

In universities, increasing managerialism has had unintended consequences for faculty resulting in the restriction of academic autonomy, disempowerment, a reduction in intellectual freedom, increased stress in academics, and increased psychological and physical violence. Employers should be aware that some organizations and universities rely on the practice of victim blaming as a useful strategy to avoid responsibility and, thus, perpetuate unhealthy and stressful environments. It is noteworthy that employees who suffer work stress are often operating under abusive work climates that organizations refuse to acknowledge or take responsibility for (Speedy, 2006). Rather than blaming the victim, universities need to examine the work environment and ensure there is zero tolerance for abusive behaviour (Speedy, 2006).

A similar situation is apparent in health care, where work stress has long been recognized but blame is attached to individual nurses, who are labeled as unable to cope with their various stressors (e.g., workload, shift work, lack of autonomy, or resource issues). Rather than acknowledging the role of inappropriate organizational structures or management factors, nurses' stress is attributed to their inability to cope or other individual deficiencies. Whether in university or healthcare settings there are no excuses for victim blaming. Creating a safe and healthy psychological environment requires a systematic, consultative, organizational approach on the part of leaders and managers (Speedy, 2006).

Definition(s):

Workplace bullying: a repeated pattern of intentional inappropriate behaviour, direct or indirect (aggressive or passive), whether verbal, physical or otherwise, performed by one or more persons against another employee or group of employees that could reasonably be regarded as undermining an individual's right to dignity at work (Koster, 2007).

Learning Activity: 5

(Answers can be found in Appendix, p. 71)

Question:

1. After reviewing the costs of workplace violence, select the ones that apply to your work environment.

Your answer: _____

Question:

2. Are any costs surprising to you? Why?

Your answer: _____

Module 2 - Is Your Organization at Risk? Are you at Risk?



Objectives for Module 2

At the completion of this module you will be able to:

- 1) identify the risk factors for violence that apply in your work environment
- 2) define vulnerable populations
- 3) identify the boundary spanners in your organization
- 4) identify those who may be perpetrators of violence in your organization
- 5) provide examples of perpetrators of violence in your organization
- 6) describe the workforce variables that influence whether violent incidents are reported in your organization
- 7) analyse whether any workforce variables influence your decision to report violent incidents
- 8) develop a strategy that your organization can consider to reduce under-reporting
- 9) complete learning activity with 100% accuracy.

Being at Risk for Workplace Violence

There are many common risk factors that can put a workplace at risk for violence. For example:

Definition(s):

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

Weapon: any inanimate object that is used in a threatening manner or to inflict harm (Farley-Toombs, 2006).

- 1) lack of staff training and policies to prevent and manage escalating hostile and assault-related behaviour
- 2) unrestricted movement of the public
- 3) low staffing levels during times of increased activity
- 4) staff working alone
- 5) staff working as a 'boundary spanner'
- 6) overcrowded, uncomfortable waiting rooms
- 7) distraught family members
- 8) long waits for service
- 9) poor environmental design (e.g., poorly lit corridors, rooms, parking lots)
- 10) staff working directly with people who are under the influence of problematic substances
- 11) easy access to drugs or money in hospitals, clinics and pharmacies
- 12) increased use of hospitals by police and the criminal justice system, for criminal holds and the care of violent individuals
- 13) increasing presence of gang members
- 14) prevalence of handguns and other weapons among patients, families or friends

(Hutchinson, Jackson, Vickers & Wilkes, 2006)

In some organizations it is not uncommon for stressors created by authoritarian managers, negative personalities and work overload to contribute to these risk factors (Hoobler & Swanberg, 2006).

Employees who have high public contact jobs are more likely to experience violence than those working in jobs with low public contact. Individuals report the most violence in their workplace if they work with vulnerable populations, work late hours, and handle money (Hoobler & Swanberg, 2006).

An interesting term described in the literature about workplace violence is 'boundary spanners'. Boundary spanners are occupations that bridge the gap between organizational members and outsiders (e.g., customer service representatives, receptionists, registration personnel, unit clerks). Individuals in these roles represent the organization to outsiders but also serve to protect and buffer it from outside forces (Hoobler & Swanberg, 2006). These occupations are subject to two demands: 1) to protect the policies and integrity of the organization, and 2) at the same time to placate difficult customers

while attempting to protect themselves from mental and physical harm. These individuals experience pressure from management, co-workers and organizational policies while also dealing with the stress due to an uncertainty of the external environment (Hoobler & Swanberg, 2006).

As well, Hoobler & Swanberg (2006) report that those who instigate violence against employees include individuals in supervisory positions, co-workers and customers. Employees experienced more verbal abuse from customers than from co-workers and supervisors. In contrast, supervisors and co-workers are more likely than customers to be perpetrators of sexual misconduct. Individuals involved in high public contact occupations were more likely to observe and experience verbal harassment and abuse.

Sadly, a relationship does exist between an increase in violence in society and violence in healthcare settings; this is evidenced by increasing violence toward healthcare professionals. Registered nurses are identified as an occupational group at considerable risk of violence-related trauma. Experiences include harassment, bullying, intimidation, and assault that may emanate from fellow nurses, nurse managers, other medical and administrative staff or clients and families (Hutchinson, Jackson, Vickers, Wilkes, 2006). The most common form of violence experienced by registered nurses is verbal abuse, followed by threatening behaviour. Perpetrators of violence in hospital settings are most commonly patients, their families and friends, and are often men. Work colleagues, volunteers, and other employees can also be involved in violent incidents (Luck, Jackson, Usher, 2006).

Those who witness violence are also at risk, and can become intimidated, uncomfortable, anxious and depressed. Research also indicates that the effects of violence extends beyond the workplace and affects both witnesses and the victim's family (International Council of Nurses, 2006).

Definition(s):

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

Learning Activity: 6

(Answers can be found in Appendix, p. 72)

Question:

1. Choose the risk factors for violence that apply in your work setting.

Your answer: _____

Question:

2. Which risk factors for violence apply in particular to you in your role?

Your answer:

- a. _____
- b. _____
- c. _____

Question:

3. Determine the vulnerable populations in your workplace.

Your answer: _____

Question:

4. Who are the boundary spanners in your organization? Why?

Your answer: _____

Question:

5. Reflect on who may be perpetrators of violence in your work setting. Provide examples of the type of violence you have experienced and/or witnessed.

Under-Reporting Incidents of Violence

Violent incidents against nurses are under-reported, and a general lack of adequate training, administrative support and political will contributes to this situation (Henderson, 2003). Ferns (2005) states that under-reporting of violent incidents is a widespread phenomenon in the nursing profession – a profession that is dominated by women. In accepting that under-reporting occurs, strategies designed to minimize violent incidents are flawed due to incomplete data. It is also important to note that significant levels of under-reporting can still occur in the workplace even when managers support, encourage and act on violent incident reporting.

One way to address this inaction is to consider the workforce variables that influence whether incidents are reported or not. The most common barrier to reporting disruptive behaviour is fear of retaliation from co-workers (Schaffner, Stanley, Hough, 2005). Other reasons that could contribute to under-reporting include the onerous process for incident reporting, a perception of rocking the boat, and the lack of consistency of definitions in the literature (Luck, Jackson, Usher, 2006).

Other workforce variables that could influence whether violent incidents are reported include:

Gender and socialization

Ferns (2005) proposes that gender and childhood socialization may explain why nurses do not tend to report incidents of violence. Since some parents view aggressive behaviour as more acceptable for boys they may actively encourage the behaviour in boys and discourage it in girls. Adolescent girls are more likely to display other forms of aggression, rather than direct physical abuse (e.g., abusive letter writing, tactics of social isolation such as peer group exclusion or gossiping).

It is suggested that female nurses – socialized from childhood to manage aggression in a covert fashion – may be reluctant to engage in formal reporting procedures; preferring to deal informally with incidents instead. Research suggests females are more likely to use indirect aggression. This may explain, in part, the role of bullying in nursing as an indirect form of aggression and nurses' reluctance to report incidents formally. If bullying thrives and is perceived as a 'normal' tactic, the aggression experienced by nurses from patients may be more readily accepted since verbal aggression from colleagues is the norm (Ferns, 2006).

Definition(s):

Disruptive behaviour: defined by the American Medical Association as personal conduct, whether verbal or physical that affects or that potentially may affect patient care negatively. It can interfere with good and safe patient care and is not limited to physicians but can include any healthcare providers (Joint Commission Resources, 2006).

Personal experiences

Personal experiences may also play a key role in whether nurses are willing to report violent incidents. For example, nurses may be afraid to recognize violence in patients for fear of having to recognize it in themselves and/or their family. This may interfere with a nurse's ability to effectively screen patients for abuse, and nurses experiencing violence in the workplace may blame themselves (Ferns, 2006).

Violence against women is a global public health issue. In Nova Scotia, 95 percent of the current nursing workforce is female. Some nurses may be involved in domestic violence either as victims or aggressors, making it less likely they will report aggression in their professional lives (Ferns, 2006). Domestic violence leads to physical and psychological trauma resulting in consequences such as social isolation, reduced confidence and self-esteem, and self-blame that can be manifested as negative behavioural traits in the clinical area (Ferns, 2006).

Since nurses' private life experiences are likely to influence their professional lives, nurses who experienced childhood sexual or physical abuse are at greater risk of sexual or physical assaults by patients. One reason why nurses may fail to report violent incidents is that the motivating factor is not time or workload but experiences of domestic assault at home (Ferns, 2006).

Nursing in society and the dynamics of power

In the current healthcare system, nursing is exposed to the influences of political will and economic change, which directly affects the work nurses do and where and with whom they practise. For example, nursing worklife has been impacted by healthcare cuts, downsizing and casualization of the nursing workforce within the past decade.

Power is a matter of authority and control. Violence in the clinical area is a power issue as is under-reporting of violent incidents. Therefore, the nursing profession needs to implement strategies that protect its members. These strategies could include encouraging staff to undertake conflict resolution training or to change healthcare delivery and health service dynamics to ensure the safety of staff (Ferns, 2006).

In some organizations, individuals can use power to keep items off an agenda and ensure that decision-making is controlled by the more 'powerful'. Nurses have faced aggression for a long time, however, this is only now beginning to receive acknowledgement. Since all knowledge is the product of power relations it is understandable that there is little published information on violence and aggression

experienced by nurses – resulting in nurses having little power to tackle the issue. A lack of data related to the true nature and incidence of violence experienced by nurses means that strategies to manage incidents will be limited in their success (Ferns, 2006).

Under-reporting has hampered the development and implementation of effective strategies to reduce violence. Nurses often passively accept abuse and violence as part of the job, an attitude that is shared by the public and the judiciary (International Council of Nurses (2006). As a profession, nursing is autonomous and controls its own work. However, in some healthcare organizations, the role of the registered nurse is diminished or missing at the senior management and intermediate management level, and registered nurses report to managers who are non-nurses. If nurses experience a lack of professional autonomy in the workplace completed reports of violence may enter the bureaucratic process and go to individuals who are not accountable to nurses in direct care. If nursing cannot instigate change autonomously then the nursing profession has little authority to effectively manage the safety of its members (Ferns, 2006).

The nursing profession is perceived to have a lack of status because it experiences excessive violence, and projects passivity by not confronting the issue. Many nurses are assaulted in the workplace and many of these incidents go unreported, emphasizing again the lack of collective and individual power that nurses are able to exert. For example, in 2003 under-reporting of violent incidents in one emergency department was estimated at 39 percent (Ferns, 2006).

Nurses accept aggression from colleagues and patients by not taking immediate action to prevent it from happening. Nurses may experience being bitten or hit by confused patients but many do not see this as aggression because there is a perceived lack of intent, yet nurses are still hurt regardless of the intent (Ferns, 2006).

Sometimes those working in the nursing profession display characteristics of oppressed group behaviour such as low self-esteem. This may also help to explain under-reporting. Staff who do not value themselves highly might be less inclined to report incidents of violence (Ferns, 2006).

If society believes there is a relationship between virtue and outcome, and that good people do not have bad things happen to them, then nurses may fear being labelled as incompetent or blamed for incidents that they report. Nurses may be tolerant of abuse because they are expected to be tolerant: not reporting incidents of violence might reflect the nursing ethic of putting patients first.

However, it is in the best interests of patients that nurses report all incidents because the knowledge generated can minimize further episodes of conflict and reduce the opportunity for, or severity of, incidents in the future (Ferns, 2006).

The challenge then is for nurses to change the culture of their workplaces and attitudes within their profession towards violence, so that reporting incidents becomes the norm and leads to changes in work practices and safety. In fact, there is a greater willingness of younger or less experienced staff to report violence.

Nurses should review current practices and ask why nurses tolerate violent incidents and do not report these incidents in the clinical setting. By taking control of the reporting process, nurses can influence policy related to protecting their personal safety and that of their patients (Ferns, 2006).

Strategies to Reduce Under-Reporting

Ferns (2006) offers the following recommendations for nursing administrators, researchers and educators to address and minimize violence in the workplace:

- 1) collect accurate data: to influence research findings and shape policy
- 2) conduct indepth investigations: to minimize assaults against nursing staff
- 3) develop strategies, based on a public health approach, to encourage nurses to report incidents
- 4) implement a robust reporting strategy, so nurses can review current practices when reporting incidents of violence or aggression.

Learning Activity: 7

(Answers can be found in Appendix, p. 72)

Question:

1. Review the section on workforce variables. Which variables influence whether violent incidents are reported in your organization?

Your answer: _____

Question:

2. Which variables influence your decision to report violent incidents? Why?

Your answer: _____

Question:

3. Choose strategies your organization could consider to reduce under-reporting.

Your answer: _____

Question:

4. Determine what steps need to be taken to discuss implementation of these strategies for change in your workplace.

Your answer: _____

Module 3 - Types of Workplace Violence

This module is divided into three sections: Threatening Behaviour, Verbal Abuse & Physical Assault, and Bullying. At the completion of this module, you will be able to:



Threatening Behaviour

- 1) name four components of workplace violence - threatening behaviour, verbal abuse, physical assault, and bullying
- 2) define the term 'threat'
- 3) describe who is most likely to make threats in health care
- 4) state why a threat should never be disregarded
- 5) discuss organizations' responsibility in supporting employees faced with a threat
- 6) list the advantages of interpersonal training for employees at risk of receiving threats
- 7) complete learning activity with 100% accuracy.

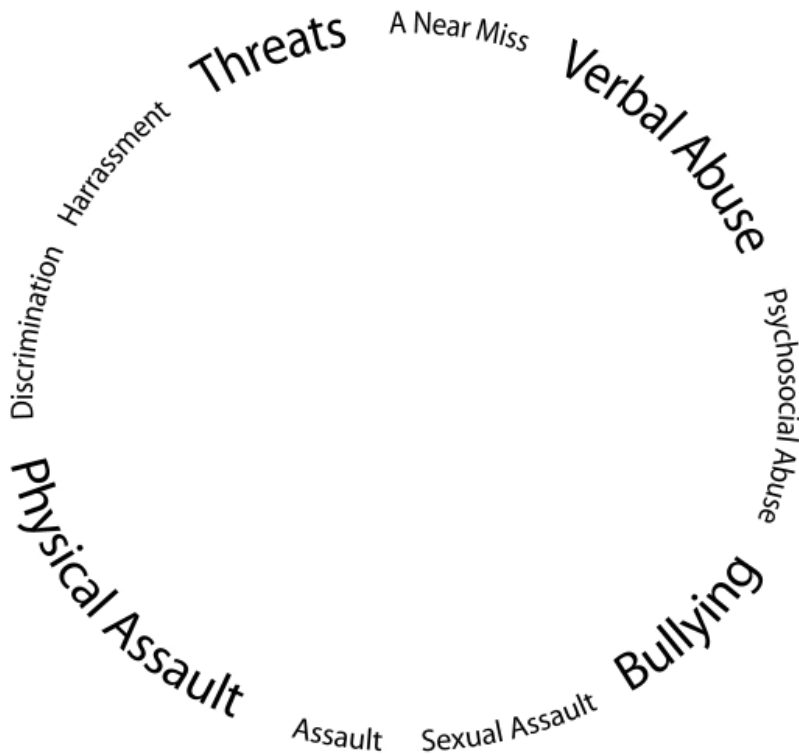
Verbal Abuse and Physical Assault

- 1) name healthcare areas where nurses are particularly vulnerable to experiencing threatening behaviour, verbal abuse and physical assault
- 2) describe the term 'disruptive behaviour'
- 3) describe three categories of disruptive behaviour
- 4) provide examples of predictors of violence
- 5) discuss the notion that nurses accept violence as part of the job
- 6) describe your experience with physical assault in the workplace
- 7) describe how you reduce the experience of physical assault in your role
- 8) describe your frustrations in dealing with violent behaviour
- 9) discuss mechanisms your organization employs to eliminate violence in the workplace
- 10) select the best response for each scenario you choose to complete
- 11) complete learning activity with 100% accuracy.

Bullying

- 1) explain why bullying is a harmful, pervasive feature of modern workplaces
- 2) provide examples of bullying behaviours
- 3) describe the impact bullying has on organizations
- 4) describe the impact bullying has on individuals – both victims and witnesses
- 5) discuss the negative effects generated by the group power of bullies
- 6) describe effects you may have experienced when bullied at work
- 7) explore why bullying may be thriving in your workplace
- 8) identify any bully-defined 'rules of work' in your workplace
- 9) determine whether you are a bully or a victim of bullying
- 10) discuss the difficulties experienced by managers in the presence of bullying behaviours
- 11) discuss your views as to whether bullying is a gender issue
- 12) choose strategies to begin the process of eliminating bullying in your workplace
- 13) complete learning activity with 100% accuracy.

Workplace violence describes a range of destructive behaviours that include threats, near misses, verbal abuse, psychosocial abuse, physical assault, assault, sexual assault, bullying, discrimination, and harassment. Since all these behaviours are bad, and none are any better than the other, this continuum of behaviour is represented as a circle.



Definition(s):

Discrimination: the unfavourable treatment of someone based on prejudice and occurs when burdens, obligations or disadvantages are imposed on a person or persons and not imposed on others. Access to opportunities, benefits and advantages is withheld or limited to some but not to others (Koster, 2007).

Violence is a complex phenomenon that the literature divides into three components – threatening behaviour, verbal abuse and physical assault (Luck, Jackson, Usher, 2006). This module includes bullying as a fourth component of violence. Bullying is a major form of nonphysical violence. Although difficult to measure in health care, it is becoming frighteningly prevalent in the workplace and can lead to psychological long-term damage (Speedy, 2006).

THREATENING BEHAVIOURS

Based on data from the United States, where most studies have been conducted, the prevalence of threats against employees working in hospitals is high. Studies show that health providers in both inpatient and outpatient settings frequently experience threats from patients, and verbal threats account for a high proportion of reported assaults.

According to Dalton, Eracleous (2006):

- the majority of those making threats in health care are male
- most threats involve a target and threatener of the same

race

- public health workers who visit bars and crack houses, work with the homeless, gang members and those with a diagnosis of problematic substance use are more likely to experience threats and violence.

Regardless of the manner in which they are made, threats should always be treated as potentially high risk and never disregarded. It would be wise to put the necessary precautions in place even if there is only a minimal risk that a threatener will actually carry out a threat. Today, the prevalence of threats is high, and the danger of being threatened is increasing. Threats account for a high proportion of reported assaults, and management should be proactive and immediate in their response (Dalton, Eracleous, 2006).

Since studies indicate that the reaction to threats in healthcare settings is not always immediate or proactive, organizations and individuals have a responsibility to ensure that their responses are both appropriate and timely. Employers and employees must be willing to work together in developing policies that will protect individuals facing threats.

Healthcare Organizations

It is the responsibility of organizations/employers to ensure that relevant policies, procedures and education are in place to support employees faced with threats. They should develop investigative techniques and strategies, as well as mechanisms to help staff report threats.

Interpersonal training for employees at risk of receiving threats is crucial. According to Hoobler & Swanberg (2006), employees need to know how to deal with violent and potentially violent situations, including how to detect and defuse potentially dangerous encounters.

For instance, organizations should ensure that their education/training sessions help employees: 1) know what they can and should say to disgruntled customers, and, 2) can recognize when it is in their best interests to exit charged situations or to call in other employees.

Employee training should include content related to:

- listening skills
- identifying offenders (threateners)

- assessing why a victim is being threatened
- assessing danger (e.g., the way a threat is delivered, content and style of a threat, level of victim risk)
- conflict negotiation
- avoidance tactics

It is also suggested that hospital teams conduct periodic reviews of threats received, the management of threats, and case outcomes, to help employers and employees improve how they deal with future threats.

Individuals

Individuals have a responsibility to be aware of organizational policies and procedures related to handling threatening behaviours, and to inform themselves of how to protect themselves and others. According to a literature review compiled by the Occupational Health & Safety Agency for Healthcare in British Columbia in 2005, de-escalation is a combination of verbal and non-verbal interactions that can help employees reduce the threat of violence. A summary of de-escalatory skills include:

- maintaining adequate distance
- explaining intentions to patients and others
- asking open-ended questions
- trying to appear calm and self-controlled
- engaging in conversation: acknowledging concerns and feelings
- ensuring that non-verbal communication is non-threatening
- moving toward a safer place, avoiding corners
- asking for any weapons to be put down (not handed over)
- knowing how to call for help in an emergency

It is important to note that assigning a risk level to a particular threat will allow for the implementation of appropriate interventions. For their own well-being it is vital that staff do not ignore threats (Dalton, Eracleous, 2006).

Learning Activity: 8

(Answers can be found in Appendix, p. 73)

Question:

1. There are many types of workplace violence. Name the four described in this module.

Your answer:

- a) _____
- b) _____
- c) _____
- d) _____

Question:

2. Define the term 'threat'.

Your answer: _____

Question:

3. What individuals are most likely to make threats in health care?

Your answer: _____

Question:

4. Why should threats never be disregarded?

Your answer: _____

Question:

5. Review organizations' responsibility regarding threats. Discuss what support should be provided for employees who have been threatened.

Your answer: _____

Question:

6. Why is interpersonal training crucial for employees who have received threats?

Your answer: _____

VERBAL ABUSE AND PHYSICAL ASSAULT

Violence in healthcare work settings threatens the delivery of effective patient services and, therefore, patient safety. If quality care is to be provided, nursing personnel must be ensured a safe work environment and respectful treatment (International Council of Nurses, 2006).

Predictors of Violence

Patients may resort to unacceptable behaviour in an attempt to obtain health care without intending to cause harm (Luck, Jackson, Usher, 2006). However, predictors of violence can include physical or emotional stressors (e.g., death of a loved one, grief, divorce, being a victim of violence), and uncontrolled feelings resulting from these types of circumstances being directed toward a health facility or nurse (Luck, Jackson, Usher, 2006).

Cognitive impairment can also be a precipitating factor for violence. For example, individuals with problematic substance use, mental illness, and those who are confused or disoriented due to acquired brain injury, dementia, medications, or anaesthesia may be more prone to violent incidents (Luck, Jackson, Usher, 2006).

Finally, environmental factors such as low or poor lighting and psychosocial/socioeconomic influences such as homelessness, financial burden, criminal activity, and domestic disputes can all be considered predictors of violence (Luck, Jackson, Usher, 2006).

At the same time, agents of violence in the hospital setting are most commonly patients, their family and friends, those who are male, work colleagues, volunteers and other employees (Luck, Jackson, Usher, 2006).

Predictors of violence are, generally, related to an individual registered nurse's position and/or role within the healthcare system. Those in direct care positions are more likely to experience violence due to their greater exposure and increased accessibility to patients, and their families and friends (e.g., continuity of care consistently exposes the same nursing staff to the same patients, families and friends (Luck, Jackson, Usher, 2006).

For example, many violent scenarios play out in ER departments, where registered nurses are faced with one or more of the above predictors of violence (e.g., patients with unknown histories; varying levels of anger, fear, anxiety, and frustration; and patients' and visitors' potential feelings of vulnerability, fear, hopelessness, loss of control, lack of knowledge or sense of protectiveness towards each other). All these elements contribute to the complexity of violence in health care.

In addition, it sometimes appears that patients verbally abuse registered nurses in the emergency department because they do not see any consequence to their behaviours. On the other hand, patients tend not to verbally abuse physicians because of the risk of being refused treatment (Henderson, 2003).

There is also overwhelming evidence that nurses consider violence as “part of the job” and this attitude may mirror the broader societal gender inequalities, particularly violence towards women. A troubling issue is nurses’ desensitization or habituation to violence in the workplace. This perception is institutionally, culturally, and professionally sanctioned and reinforced as the norm and may be why nurses under-report verbal violence (Luck, Jackson, Usher, 2006).

Definition(s):

Disruptive behaviour: defined by the American Medical Association as personal conduct, whether verbal or physical that affects or that potentially may affect patient care negatively. It can interfere with good and safe patient care and is not limited to physicians but can include any healthcare providers (Joint Commission Resources, 2006).

It is suggested that the perpetration of violence is influenced by an individual nurse’s violence management strategies (e.g., being equipped to identify the warning signs of violence and responding by de-escalating the potential for violence prior to an incident). This assumption is unproven and so the focus of concern must rest on the agent of violence (Luck, Jackson, Usher, 2006).

A growing body of literature recognizes nurses are profoundly vulnerable to abuse, threat, violence and injury in the workplace. In addition, many nurses feel unsupported, invisible and de-valued by others in the healthcare system (Henderson, 2003). It is clear that nursing needs new ways of dealing with the ongoing problem of violence directed towards nurses (Luck, Jackson, Usher, 2006).

Verbal Abuse and Disruptive Behaviour

Much of the current research on violence in the workplace comes out of Australia, where nurses report a higher rate of occupational violence than other healthcare providers, with the most common form being verbal abuse (Luck, Jackson, Usher, 2006).

Communications essential for safe patient care break down when people experience disruptive behaviour. This results in a reluctance to ask questions and to engage in meaningful discussions that affect patient care (Joint Commission Resources, 2006).

‘Disruptive behaviour’ can affect patient care negatively, interfering with good and safe patient care. Categories of disruptive behaviour include: physical intimidation and violence; unpleasant and abusive behaviour; and refusal to cooperate.

Physical intimidation and violence includes extreme behaviour such as throwing objects, pushing co-workers, tantrums, and yelling directly in someone’s face (Joint Commission Resources, 2006).

Unpleasant and abusive behaviour includes demeaning other team members through overt sarcastic remarks, and encompasses covert actions and statements that undermine co-workers professionally (Joint Commission Resources, 2006).

Refusal to cooperate relates to an individual's refusal to follow directives, cooperate with group decisions or accept input (e.g., a nurse who 'knows it all' and won't listen to anyone else (Joint Commission Resources, 2006).

Physical Assault

In the United States, hospital workers are more likely to be assaulted on the job than employees in other industries. Henderson (2003) conducted a research study in Canada and the United Kingdom to determine nurses' experiences of violence and abuse in the workplace and how it influenced their ability to care for patients. Through the study it became apparent that nurses experience significant threat at the hands of patients and their relatives and routinely encounter verbal abuse and physical assault.

In the study, nurses working in emergency, mental health, maternity, medical-surgical and community health were interviewed. Individual nurses reported being kicked, punched, bitten, bruised by being held, followed after work, threatened with a weapon, pushed, thrown to the ground, pulled by the hair, choked, knocked unconscious, and subjected to death threats (Henderson, 2003).

Several community nurses reported being ridiculed by general practitioners and their managers at a case conference when they decided that specific clients were too dangerous to visit in the home setting, and were told subsequently to continue visiting. Interestingly, a policeman attending the conference supported the nurses' decision to trust their instincts and shared information about convictions for violent assaults on women (Henderson, 2003).

Nurses have described being threatened when alone on hospital units, including dealing with a knife-wielding patient during the triage process. Maternity nurses described not only concern for their patients with abusive partners but also for themselves, and shared their feelings of conflict and helplessness produced by these situations. Many nurses recalled being physically attacked at work, but made a clear distinction between violence committed by clients who were hypoxic or psychotic versus those who were angry and upset and should know better. They accepted a certain level of violence as inevitable if it was beyond a patient's control (Henderson, 2003).

In opposition to this view, one nurse was confronted by danger during a home visit, which was made with two police officers and a

physician. In anticipation of potential risk, the police were prepared and had brought personal protective equipment – the doctor and nurse had none. The nurse recognized that the police take precautions – healthcare professionals less so (Henderson, 2003).

Community nurses often make home visits alone in deprived and dangerous areas; leaving the office early in the morning with no contact with colleagues until late in the evening. Community-based nurses are routinely exposed to more potentially lethal situations than hospital-based nurses by virtue of their isolation. They are exposed to unknown dangers in households as well as on the street. To cope, nurses either put the risk of danger at the back of their minds or stay aware of the need for vigilance (Henderson, 2003).

In turn, most community-based nurses, consciously or unconsciously, routinely place themselves physically in a safe position from the client (e.g., not letting the client between them and the exit, ensuring that a client doesn't lock doors, remaining aware of a client's affect and positioning their own body for a quick exit – knees towards the door and uncrossed). They also monitor the environment around the home and minimize threat by avoiding being hemmed in, walking close to the road and away from doorways, and being aware of other people in the environment (Henderson, 2003).

Nurses in the study felt there was a lack of understanding or support from other health professionals about nurses' safety. Often they were not supported in their decisions to charge violent patients or not to go into community settings they viewed as unsafe. By definition, to be a nurse means being exposed to danger in the form of violence without support (Henderson, 2003).

If nurses are to support others, they must feel supported and safe themselves. A strong message must be sent to nurses, other health team members, administrators and the public that nurses are a vital part of the healthcare team and are not to be misused or abused. Only when measures are in place to protect nurses will they be secure enough to advocate for their clients (Henderson, 2003).

When support from other healthcare professionals or administration remain inadequate there are implications for nurses' health and safety and also for the profession in attracting and retaining nurses in the healthcare system.

Learning Activity: 9

(Answers can be found in the Appendix, p. 74)

Question:

1. Name some healthcare settings where nurses are particularly vulnerable to experiencing threatening behaviour, verbal abuse and physical assault.

Your answer:

- a) _____
b) _____
c) _____

Question:

2. Define the term 'disruptive behaviour'.

Your answer: _____

Question:

3. Name three categories of disruptive behaviour and provide examples of each.

Your answer:

- a) _____
examples: _____

b) _____
examples: _____

c) _____
examples: _____

Question:

4. The following statements relate to predictors and/or agents of violence.

Choose the correct response.

- a) Only patients are agents of violence
b) Uncontrolled feelings after a death
c) Cognitive impairment
d) A nurse's lack of experience
e) A participant in a domestic dispute
f) Those in direct care are less likely to experience violence

True or False

- | | |
|---|---|
| T | F |
| T | F |
| T | F |
| T | F |
| T | F |
| T | F |

Question

5. Do you consider violence as part of your job?
Why or why not?

Your answer: _____

Question

6. In your role, describe an experience you might have had or witnessed involving physical assault.

Your answer: _____

Question:

7. How have you reduced your risk in experiencing physical assault in your role?

Your answer: _____

Question:

8. Share any frustrations you have experienced in dealing with violent behaviour in your workplace.

Your answer: _____

Question

9. Explore what your organization is doing to eliminate violence in the workplace. List these activities below.

Your answer: _____

Scenarios: Violence in the Workplace

(adapted from Alexy, E.M., Hutchins, J.A. (2006). Workplace violence: A primer for critical care nurses. *Critical Care Nursing Clinics of North America*, 18, 305-312.)

The following scenarios are based on a framework of four types of violence:

- Type I - Criminal Intent
- Type II - Customers/Clients/Family Members
- Type III - Employee on Employee
- Type IV - Personal Relationships

Review the scenarios and discussions, then write a response based on your own ideas and compare with the ‘best response’ provided.

Scenario 1

Alicia, a registered nurse, is working in the emergency department when a man suddenly appears and produces a handgun. He demands that she give him all the OxyContin tablets available.

Discussion

This scenario illustrates type I violence – Criminal Intent. This type of violence occurs while a criminal activity is being committed and the offender has no legitimate affiliation with the workplace. Efforts to prevent type I violence should focus on assessing environmental risks and increasing security measures, and many agencies have begun installing silent panic buttons, streamlining access to hospital and unit entrances, installing metal detectors and security cameras, and increasing the presence of armed security personnel. Additional measures include providing personnel with cell phones, 2-way radios, and escorts to and from parking areas. If type I violence is not addressed in agency policies, nurses must be part of an interdisciplinary team that develops and regularly reviews policies (Alexy, Hutchins, 2006).

Your response: _____

‘Best Response’

The best response to this violent assault would be to comply with the offender’s request. Safety is the highest priority. Nursing assessment skills are extremely beneficial when dealing with this type of violence. Observations that could assist in identifying and arresting the offender include the offender’s:

- clothing, especially what is underneath the outer layer – that can be removed
- physical characteristics (e.g., height, weight, eyes, hair, mannerisms, scars and tatoos)
- direction of escape and mode of transportation (Alexy, Hutchins, 2006).

Scenario 2

Martha works in a neurosurgical ICU and is caring for a patient with a traumatic brain injury, affecting his frontal lobe, sustained in a motorcycle crash. While being assisted with bathing, the patient suddenly punches her in the face. She sustains a fractured jaw.

Discussion

This scenario illustrates type II violence – Customers/Clients/Family Members. This type of violence involves an offender who becomes violent while being taken care of by a healthcare provider. This is the most prevalent type of workplace violence occurring in healthcare settings.

Other risk factors related to scenarios such as this one could include metabolic disorders, mental illness, intoxication, drug overdose, drug/alcohol withdrawal, and cognitive disorders such as dementia.

Even if the client did not intend to injure the nurse, the consequences of an unintentional act of violence can result in low staff morale, burnout, absenteeism, and increased staff turnover (Alexy, Hutchins, 2006).

Your response: _____

‘Best Response’

Given the patient’s medical history, the nurse may not have been able to prevent this injury. While providing care the nurse should have been observing the patient for signs of increased restlessness (e.g., due to discomfort or agitation). These cues should prompt the nurse to stop the bedbath, talk to the patient, assess for environmental irritants, and only resume care when the patient is calmer. If the patient’s restlessness escalated, comfort measures and/or medications could be provided.

Physical attacks can and do happen. Incidents such as this one must be reported because a physical injury was sustained and the nurse required medical attention (Alexy, Hutchins, 2006).

Scenario 3

A parent in a pediatric ICU shouts loudly at Mark, the clinical nurse specialist, “Can’t you see my son’s in pain - I don’t want to hear your excuses – give him more pain medication now, right now or I’ll make you feel the way he does!”

Discussion

This scenario also illustrates type II violence – Customers/Clients/Family Members: Verbal threat. Verbal threats are among the most common forms of workplace violence encountered by nurses. Violence can intensify due to inaccurate perceptions, intolerance, misunderstandings, and lack of control. Early cues of increasing agitation include the use of profanity, rapid or loud speech, pacing and fidgeting. Verbal threats are themselves cues to a potentially escalating violent situation (Alexy, Hutchins, 2006).

Your response: _____

‘Best Response’

The nurse should attempt to de-escalate the situation with firm, short and simple empathetic responses. Such statements can often disarm a potentially violent situation by calling attention to a parent’s own behaviour. If the parent continues to display escalating behaviour, security may have to be called to escort the parent from the unit to a quieter environment such as the ICU family room (Alexy, Hutchins, 2006). Here, with support from the nursing team leader or social services, the parent could engage in a therapeutic conversation to help work through his/her feelings and perceptions.

To refine prevention and assessment efforts, all type II violence must be reported. By not reporting this type of violence, healthcare providers and agencies reinforce to the public and other staff the belief that such incidents are accepted and are ‘part of the job’. Encouraging such a belief is a disservice to the nursing profession because it promotes a culture in which some violence is expected and accepted. Reinforcing this belief sends a mixed message to nurses because it conflicts with organizations’ zero tolerance workplace violence policies. Reporting processes must be simplified (Alexy, Hutchins, 2006).

Scenario 4

Wanda, a registered nurse, works in the operating room and loves her job. However, she dislikes her hostile working environment. Everyday, she and others experience verbal abuse from the nursing clinical leader. Today, when returning from a scheduled break, Wanda is grabbed by the arm and yelled at by the clinical leader to go back into the OR. In fact, this particular clinical leader routinely dispenses verbal abuse to all nurses, denies nurses' vacation time and belittles their nursing skills.

Discussion

This scenario illustrates type III violence – Employee on Employee. This type of violence involves employees or past employees of a workplace who are the offenders. In health care settings, this type of violence occurs on a daily basis and includes behaviours such as intimidation, bullying, interpersonal conflict, and verbal and psychological abuse. This type of violence can lead to long-term psychological trauma, and the impact for the individual and organization can be as great as, if not greater than physical violence. It is also more widespread, involving colleagues, witnesses to the violence, family and friends (Alexy, Hutchins, 2006).

In this scenario, a repeated pattern of verbal abuse escalated to a physical assault. This type of violence is hard to manage because it moves into a cycle of blame and denial without successful resolution. Often these incidents are denied by the offender or blamed on events such as working conditions, patients, colleagues or administration (Alexy, Hutchins, 2006).

Even so, these causes do not justify the behaviours of type III violence (Alexy, Hutchins, 2006). In particular, a recent study of new graduates in their first year of practice indicates that 58% felt undervalued and 34% felt emotionally neglected by their nurse colleagues. Thirty-one percent experienced a distressing event such as rude, humiliating, or abusive comments, or being given too much responsibility with lack of supervision. Of those experiencing these incidents, one-third considered leaving the profession as a result of the incident (Alexy, Hutchins, 2006).

Your response: _____

'Best Response'

When presenting a scenario of this type to organizational leaders, written documentation of the incident and availability of people to

support and validate the victim's claim strengthen the submission. In this particular case, identifying, documenting, and reporting the verbal behaviours may have prevented the physical assault. If organizational leaders do not take reports of type III violence seriously, physical injury can result. For this reason it is essential that healthcare organizations adopt a zero-tolerance policy regarding workplace violence (Alexy, Hutchins, 2006).

Consequences of type III workplace violence can be anxiety, depression, burnout, increased staff turnover and nurses leaving the profession (Alexy, Hutchins, 2006).

Scenario 5

Gerry, the husband of a nurse in the cardiac care unit, rushes into the unit and in front of numerous co-workers shoots his wife, Margo, before fleeing. The previous day, the couple had had an altercation that led Margo to the police to file a complaint. Gerry met her at the police department and the officers convinced them to have a 'cooling off' period. Margo went to work, while Gerry went home to pack a bag. An hour later he showed up at the CCU and shot his wife (Alexy, Hutchins, 2006).

Discussion

This scenario illustrates type IV violence – Personal Relationship. This type of workplace violence occurs when the offender has a personal relationship with an employee and involves domestic or intimate partner violence (IPV) that spills over into the workplace. Not wanting to be intrusive, nurses may be afraid to ask questions when they suspect that a colleague is a victim of intimate partner violence. In scenario 5, nurse colleagues may have been able to recognize early warning signs such as:

- a change in personality
- frequent unexplained bruises or injuries
- inappropriate clothing worn to cover injuries
- frequent vague complaints of stress-related disorders (e.g., headaches, backaches, sleep disturbance, increased use of drugs or alcohol)
- deterioration in work performance with an increase in phone calls, pages and e-mails throughout the day.

One way in which to prevent this type of violence is to identify the problem early and formulate a safety plan (Alexy, Hutchins, 2006).

Your response: _____

‘Best Response’

There are general strategies that nurses can follow to assist a colleague who is a victim of IPV, including: asking the question, expressing concern, listening and validating, offering help, and supporting the victim’s decisions. It is essential that nursing colleagues avoid gossiping about the situation. By offering assistance, the nurse involved may feel secure enough to seek additional assistance. Nursing colleagues should candidly state concerns for the safety of the nurse involved, and use the nursing process and problem solving skills to assist in forming a safety plan or to pursue additional options (Alexy, Hutchins, 2006).

Intimate partner violence needs to be addressed specifically in healthcare organizations’ workplace violence policies, with a focus on prevention, protection and assistance. Procedures for confidentially reporting incidents of intimate partner violence, as well as education on the issue and the availability of resources for victims are essential to maintain a safe work environment. Organizations can also assist victims by implementing policies such as paid time off, extended leaves of absence, flex-time or workplace relocations (Alexy, Hutchins, 2006).

Regardless of the type of workplace violence, the effects do not disappear after the incident, nor do they harm only the victim. Individuals have varied responses to violent incidents and may internalize (e.g., become depressed, withdraw) or externalize (e.g., become angry, have fluctuating moods) their emotional and behavioural responses. Organizations need to provide support and debriefing for all staff affected by violence to facilitate healing and prevent long-term psychologic effects (Alexy, Hutchins, 2006).



BULLYING

(Adapted from: Hutchinson, M., Jackson, D., Vickers, M., Wilkes, L. (2006). They stand you in a corner; you are not to speak: Nurses tell of abusive indoctrination in work teams dominated by bullies. *Contemporary Nurse*, 21(2), 228-238.)

Bullying is a global concern and is identified as the most concerning form of aggression or violence experienced by nurses. Links are being drawn between the recruitment and retention crisis in the nursing workforce and bullying (Hutchinson, Jackson, Vickers, Wilkes, 2006). A predominately female workforce, socialized in covert rather than direct aggressive tactics could offer one possible explanation for the extent of bullying experienced by nurses (Ferns, 2006).

Bullying is a pervasive and harmful feature of modern workplaces, and large-scale studies show there is a damaging effect both for individuals and organizations. Workplace bullying is deliberate with an ongoing array of often subtle and masked negative behaviour and actions that accumulate over time. It is experienced as being gradual, cumulative, often hidden and intensely harmful. Bullying is described as unrelenting, calculated, and deliberate, causing psychological harm, physical illness and eventually resulting in an inability to work (Hutchinson, Jackson, Vickers, Wilkes, 2006).

Examples of bullying behaviours:

- an RN ignoring a new graduate's request to review a procedure before performing it on a patient
- two RNs rolling their eyes and making snide remarks in a staff meeting when another RN is asked to clarify a new policy
- a physician yelling at a nurse over the phone, when called at night regarding a patient's status

(Schaffner, Stanley, Hough, 2005).

The Impact of Bullying

In organizations, bullies are deemed responsible for lowered morale, reduced productivity, increased staff turnover, and increased sick leave. They are also responsible for nurses leaving the profession (Hutchinson, Jackson, Vickers, Wilkes, 2006).

A lack of recent Canadian statistics on bullying in health care forces a reliance on international studies. In Australia, workplace bullying is estimated to cost businesses as much as \$13 billion a year. In the United States, for each person subjected to bullying the cost is estimated at \$30,000 – \$100,000, including the loss of productivity and the need for intervention by organizational members. Research shows that 25 percent of bullied employees leave their jobs.

Victims of bullying report experiencing anxiety, depression, and a loss of self-confidence, self-esteem, sense of worth and belief in their competency. They feel demeaned, inadequate, helpless and physically ill. They are also at risk of post-traumatic stress disorder, premature death, suicide, homicide, heavier smoking, excessive drinking, drugs, overeating and loss of relationships. Victims of bullies who suffer post-traumatic stress disorder, can take four to five years to recover, and some never do. A more subtle and long-lasting effect of bullying is the reinforcement of a fear-based culture at work (Speedy, 2006).

Bullying also impacts witnesses of these behaviours. A ‘ripple effect’ is created and witnesses report the following reactions: increased stress levels, feeling sorry for the victim, worrying about becoming a victim, being fearful of taking action, changing jobs to avoid the problem, working harder in the hope of not becoming a victim or joining in with the bullying – although the latter is rare (Speedy, 2006).

The Group Power of Bullies

Bullies wield considerable power within nursing teams; confident that other bullies and bully managers will conceal their behaviour. They establish ‘rules of work’ that are ruthlessly enforced: they ignore, deny or minimize the bullying, and frame those who were bullied as being too weak to be a ‘good’ nurse.

In one study, one-third of the nurses interviewed had moved onto other nursing positions and, while successful in their new work, carried considerable legacies from their bullying experiences (Hutchinson, Jackson, Vickers, Wilkes, 2006).

Based on the study, few of those identified as bullies on nursing teams hold formal positions of authority – instead, they hold extensive power by operating together to control work practices. They work together in long-lasting alliances, perpetrating abuse and harm that is experienced by many different people. For example, bullies elect to work together on certain days knowing that their victim is also working that day and can be ganged up on. A significant factor that permits bullies to assume power is the protection they receive from more senior bullies. Study participants commented:

An alliance of three bullies who are registered nurses had worked on the unit for a long time – in fact, one had never worked anywhere else – and they were all friends. They were a strong force and opposed anything different. They were fairly united, stuck together and were quite a force ...

... we met with the Director of Nursing in response to the report of bullying and she began the meeting by saying she didn't believe in bullying – bullying is only seen in the playground ...

Although not formally acknowledged, the prevalence of bullying is a frequent occurrence. Those who come to work on units quickly come to understand who is in control and what the established patterns of bullying are.

... I was fearful of them because I thought I was going to be in their line of fire, especially when other staff talked about how they tried to do something but nothing ever happened – so you know you are in the line of fire at that point.

One group of bullies had worked together for 15 years, controlling the team, and in the process caused extensive harm to many nurses. The unit manager tolerated and ignored the bullying behaviour, ensuring it slipped under the radar.

... the behaviour was just accepted. When reported to the manager, she said not to worry about it - that's just the way this person is. You'll get over it ... just learn to live with it ...

Bullies in this example ran the show and were considered 'untouchable'. Two participants in the study reported that of ten colleagues known to be victims – five resigned, and one committed suicide as a result of the bullying. Another participant saw six colleagues leave almost at the same time (Hutchinson, Jackson, Vickers, Wilkes, 2006).

Participants describe serial bullies as those who develop long-lasting alliances and follow a pattern of repeated acts of bullying on specific individuals. Serial bullies have an extensive history of abuse, and work cooperatively to target individuals. Bullies are seen as protected and untouchable. Bullying is often minimized, trivialized, denied, condoned and/or sustained by senior staff over a long period of time (Hutchinson, Jackson, Vickers, Wilkes, 2006).

Bully-Defined 'Rules of Work'

Nurses reveal that 'bully-defined rules of work' are successfully maintained by enforcing a hierarchal division of labour, with elements of militarism, public humiliation and tactics of exclusion. Indoctrination processes resemble techniques of torture. Those not on the side of bullies are made to feel powerless, newcomers are

bullied into submission, and bullies scrutinize every aspect of a target's personality and capabilities (Hutchinson, Jackson, Vickers, Wilkes, 2006).

... I learned just to deal with it. I changed my practice and that was to go off, do my own work, keep myself in my rooms and not go near the nursing station ...

Subtle forms of exclusion experienced by nurses are described as 'not including me in general conversation' or 'walking into the room and not speaking to me' or 'grunting and totally ignoring me'. Nurses commented that being ignored reduced them to the point of being unable to ask for help.

... new nurses are pretty isolated, they have to find their own way – they are not helped and they are not given a lot of time ...

To survive, participants revealed that they learned to hide that they were competent, capable, experienced nurses and instead appeared insignificant by being withdrawn and invisible. One nurse described experiencing wide-ranging humiliation and verbal abuse as a result of continued bullying. She felt her thoughts were controlled and she began to feel unreasonably dominated (Hutchinson, Jackson, Vickers, Wilkes, 2006).

... when the charge nurse comes into the patient's room to take control of patient care, you are to stand silently in the corner, you are not to speak and you are not to have any input – you stay in your place and don't move out of it.

Organizational Reinforcers of Bullying

Senior management who sanction bullying reinforce bully-defined 'rules of work'. Those in authority who ignore or minimize bullying lead targets to believe that their experiences are 'minimal' or 'trivial' and not cause for distress. This reinforces self-doubt, self-blame and allows abuse to escalate.

Bullies in positions of authority portray themselves as doing the targets a favour by forgiving their 'inability to cope' during relentless bullying (Hutchinson, Jackson, Vickers, Wilkes, 2006).

... I was left with the impression, after speaking with the manager that it's my problem – that it really wasn't bullying – that it's just something subtle that I'm doing wrong – maybe I'm not a good clinician – and you know I think they are right ...

... I was told I wasn't cut out for the job – that I was stressed and not coping. In fact, it was suggested that I be moved to another unit ...

Bullies who seek to break the physical and psychological stamina of targets, in order to ensure eventual compliance, work to ensure that bullying behaviour is the norm on healthcare teams. Tactics such as isolation, criticism, sabotage, and invalidation are used to erode the self-confidence and professional image of those targeted. Turning a blind eye to bullying effectively sanctions and enables the abuse. The end result is that targets remaining in the organization eventually find themselves controlled by bullies. The methods of domination, coercion, and entrapment used by workplace bullies are similar to strategies known to be used by torturers (Hutchinson, Jackson, Vickers, Wilkes, 2006).

... I am an absolute idiot and I am obviously not good at what I do. Feeling this way about myself in the workplace has a very bad effect on me. I found I didn't want to go to work, I didn't want to leave my house – I didn't want to do anything except lay in bed and pull the covers over my head and hope that it would all go away. It is very hard to get out of such a rut. It had a huge effect on my work life as well as my personal life ...

Ongoing abuse and trauma can result in profound, permanent, psychological change for individuals working in bully-prone organizations. Tyranny and coercive control can be exercised on work teams with the aim of enforcing what is considered the norms of behaviour. The coercive and controlling strategies employed by bullies are not always apparent; often masked behind a façade of organizational legitimacy. Those who bully others present their behaviours as legitimate work practices, intending to ensure the smooth flow of work. In reality, their behaviour is a form of surveillance, coercion, and control aimed at ensuring that targets are forced to learn to abide by the rules (Hutchinson, Jackson, Vickers, Wilkes, 2006).

Although bullying can be part of a more broad socialization process to nursing roles and tasks, bullying in this study focuses specifically on the indoctrination process to nursing unit teams, where the primary purpose of bullying was to bring about a fundamental change in the person targeted. Bullies seek to change how individuals think about themselves, by eroding their self-image, destroying their self-confidence and shattering the fundamental values they hold about their world and themselves. The workplace becomes a psychic

prison, a place of relentless attention to rules and strict adherence to discipline and obedience (Hutchinson, Jackson, Vickers, Wilkes, 2006).

Managers and Bullying

Inexperienced managers promoted beyond their experience and ability and without the benefit of a merit process can fall into the trap that is set by an alliance of bullies. Typically, these managers are insecure, and focused on furthering their career ambitions at any expense. If they lack personal power they may misuse their legitimate role power (Speedy, 2006).

Bullying by line managers is common. Increasingly, managers are witnessing and condoning bullying by employees and ignoring or denying its existence. An abusive boss primarily seeks to control others by creating fear, confusion and intimidation, resulting in personal reactions that include stress, helplessness and work alienation (Speedy, 2006).

A bully's power often comes from strategic alliances created with bullies in positions of authority in an organization: alliances that can occur even when well-developed, high profile bullying policies and procedures are in place.

These alliances enable bullies to regulate behaviour and work practices in teams through abuse and domination, and to ensure that even when reporting is encouraged the experiences of targets will be minimized, ignored or denied.

These findings call into question the adequacy of 'zero-tolerance' policies in responding to entrenched forms of bullying that are embedded in organizations (Hutchinson, Jackson, Vickers, Wilkes, 2006).

Gender and bullying

Bullying is sometimes viewed as a gender issue even though the evidence from the nursing literature suggests that this is not the case. In an Australian study, reported by Speedy (2006), it was determined that:

- 50% of all bullies are female
- female bullies target other females 84% of the time
- male bullies target females 69% of the time
- females are the majority of targets in the workplace
- the vast majority of bullies (81%) are bosses, some are co-workers and a few bully 'up the ladder'.

In fact, males and females are equally responsible for bullying behaviours. Female bullies tend to target females, and since males hold most positions of authority, females are most often their targets. Female bullies are more subtle and devious; men are more physically aggressive and action-oriented. In female-dominated professions, women often emulate men and try to dominate using aggressive behaviours. If women continue to perpetuate workplace patriarchy they become poor role models for women, supporting a system to keep women subordinate (Speedy, 2006).

Research indicates that nurses are the most common perpetrators of bullying behaviours against other nurses in the workplace. Bullying is a serious issue for nurses and varies from open aggression and hostility to covert rumour-mongering and exclusion. If workplace violence is accepted as part of the job, and nurses who are targets are unable to effectively contribute to the workplace, it is likely they will leave the profession altogether (Speedy, 2006).

Taking Responsibility to Eradicate Bullying

In the workplace, the fear created by bullying actually gives power to bullies; power that is often sustained through the silence of targets and witnesses who fear retribution for raising awareness of the bullying. In turn, their silence further accenuates their feelings of powerlessness. Eradicating the epidemic of bullying calls for naming the problem and taking action - and that takes courage.

Nurses are well aware that by speaking out against bullying behaviours they risk not only damaging their relationship with a manager and/or others but also losing their credibility and reputation, not to mention their potential for career advancement and/or continued employment (Speedy, 2006).

Regrettably, some organizations use victim blaming as a way to avoid taking responsibility for the problem of bullying. Use of this strategy condones unhealthy and stressful work environments. It should be noted that employees who suffer work stress are often working in abusive work climates that organizations refuse to acknowledge or take responsibility for. Organizations need to stop victim blaming and take responsibility to change work cultures that support bullying behaviour (Speedy, 2006).

Evidence is mounting that nurses are both perpetrators and targets of workplace violence, and need to squarely face, challenge and eradicate bullying behaviours. Since the nursing workplace literature indicates that women are capable of brutality, it is most desirable that women extend a helping hand to other women (Speedy, 2006).

Women who do not support other women are referred to as ‘Queen Bees’ – who are highly toxic in the workplace because they betray their own. The view of these women is ‘I made it without help, and so can you’ (Speedy, 2006).

Creating safe and healthy psychological environments requires a systematic, consultative, organizational approach on the part of everyone, including leaders and managers. A new vision of workplace relationships involves attention to interpersonal relationships and ensures collegiality, collaboration, mutual respect, trust, commitment to each other, and honesty (Speedy, 2006).

Strategies to Address Bullying

Koster (2007) states that three things must happen within organizations in order to change workplace cultures:

- 1) Increase awareness of bullying behaviour: conduct assessments to determine if bullying behaviour exists and to increase awareness of bullying behaviour
- 2) Provide all staff with education related to bullying
- 3) Implement organizational strategies to develop and ensure the:
 - a) use of evaluation tools to test whether current or potential employees have a tendency to bully others
 - b) implementation of a code of practice governing conduct in the workplace: may help shift organizations from confrontational to cooperative cultures in which staff rely on a problem solving rather than punitive approach, and encourage the development of critical leadership skills to have difficult and courageous conversations – especially for managers (Speedy, 2006).

Learning Activity: 10

(Answers can be found in the Appendix, p. 74)

Question:

1. Why do you think bullying is such a harmful and pervasive feature of the modern workplace?

Your answer : _____

Question:

2. Provide examples of bullying behaviour you have experienced or witnessed in your workplace.

Your answer : _____

Question:

3. What impact does bullying behaviour have on organizations?

Your answer: _____

Question:

4. Describe the impact bullying can have on individuals. Relate your own experiences, if any, or describe what you may have witnessed in your workplace.

Your answer : _____

Question:

5. Discuss the negative effects resulting from the group power of bullies.

Your answer : _____

Question:

6. Examine your own work environment. Describe any signs that indicate bullying behaviour is thriving.

Your answer: _____

Question:

7. Can you identify any bully-defined 'rules of work' in your current work environment? If yes, please describe. If no, please identify what behaviours you could watch for.

Your answer: _____

Question:

8. After reviewing this section, what behaviours indicate that you have been or are now a bully? or What behaviours indicate that you have been or are now a victim of bullying?

Your answer:

Bully	OR	Victim

Question:

9. Managers can be involved in bullying behaviours. If you are a manager, please answer with this question. If not, please go to question 10.

Choose the correct response.

True or False

As a manager:

- | | | |
|---|---|---|
| a) I believe bullying only exists on the playground | T | F |
| b) I believe newcomers have to 'prove their worth' | T | F |
| c) I offer to mentor inexperienced managers in recognizing the subtleties of bullying behaviour | T | F |
| d) I seek feedback from all staff when responding to reports of bullying | T | F |

Question:

10. In your view is bullying a gender issue? Why or why not?

Your answer: _____

Question:

11. If you have identified bullying behaviour in your workplace, what strategies could begin a process for change?

Your answer: _____

Bullying and Nursing Students

At the completion of this section you will be able to:

- identify factors that contribute to students' feelings of vulnerability
- review the guidelines as provided by web link

Health Canada (2002) reports that nursing students experience violence and abuse in their schools of nursing. Students in a 1995 study noted the following factors contributed to their feelings of vulnerability:

- a culture of high expectations
- personal feelings of powerlessness
- low self-esteem
- lack of confidence in clinical competence
- remote relationships with faculty as all.

Recommendations for program curriculum include taking strategies to enhance the self-esteem of students, improve student-faculty-preceptor relationships, and ensure supportive clinical learning environments.

Unfortunately, clinical settings are not a safe haven. Violence perpetrated by patients, physicians and co-workers and directed at healthcare providers, can impact nursing students. Increasingly, the safety of nurses and nursing students is emerging as a critical concern for the profession (Health Canada, 2002).

The development of educational programs can help nursing students deal with issues of violence in the clinical setting. In addition to this resource, a website developed by the Royal College of Nursing in the United Kingdom (rcn.org.uk/members/downloads/student-bullying.pdf) hosts a guide aimed mainly at nursing students to assist them in recognizing if they or a colleague are being bullied, and in addressing bullying and harassment (it also aims to raise awareness among employers and educators of steps to be taken to follow through with zero-tolerance violence policies).

The guide also provides information on topics such as the effects of bullying on targets, steps on how to move forward, and different action options.

Module 4 - Strategies



Objectives for Module 4

At the completion of this module you will be able to:

- 1) choose the most appropriate strategy to eliminate violence in your workplace
- 2) begin a process for eliminating violence in the workplace.

To assist you and your organization in developing a plan to prevent violence, a number of resources, including websites, are highlighted in this module for your convenience.

A STRATEGY IN NOVA SCOTIA

In Nova Scotia, employers have an obligation to ensure all employees have a safe working environment. Keeping safe at work includes measuring and reducing the risk of workplace violence. The Department of Environment and Labour (Occupational Health and Safety Division) has developed Violence in the Workplace Regulations. If your organization is obligated to apply these regulations, please review them for more details on how to:

- 1) develop a violence risk assessment
- 2) determine significant risk in your workplace
- 3) develop a violence prevention plan (i.e., including a policy statement, measures to lessen or eliminate the risk of violence, procedures for information and training, procedures to report, document and investigate incidents)
- 4) re-assess risk

It is imperative that organizations use this information, not hide it away on a shelf, and ensure that their violence prevention plans are 'live' documents.

STRATEGIES FROM THE LITERATURE

No matter which way you look at it, it's violence.

This article shares several ideas for addressing bullying in the workplace and changing troubled workplace cultures. As part of a healthy work environment initiative, one health centre is conducting a study to examine the perceived vulnerability of nurses to bullying and to confirm or negate the presence of such behaviour among nursing staff. Data from the study will be used to provide direction for further studies on and interventions to combat bullying.

Organization-wide efforts that support incident reporting and instill confidence in follow-up are required to combat bullying. Some organizations have adopted zero-tolerance for bullying and have policies in place that both define what bullying is and steps a victim must take to enact these policies. Mechanisms to teach effective ways of managing stress should be included in these policies.

This article also outlines the steps proposed by the Institute for Safe Medication Practices to lay a foundation for changing a troubled culture.

- 1) Establish a steering committee to define workplace violence/intimidation and establish a plan of action.

- 2) Create a code of conduct and have new and current staff sign the code upon hiring and annually.
- 3) Survey staff attitudes about bullying behaviour.
- 4) Open dialogue by holding frank discussions, with objective moderators.
- 5) Establish a standard, assertive communication process (e.g., cues of appropriate responses to common forms of bullying attached to staff ID badges).
- 6) Establish a conflict resolution process: clearly stated in a professionalism policy and to include chain-of-command guidance as an avenue for resolution.
- 7) Encourage one-on-one conflict resolution and a mechanism for confidential reporting.
- 8) Enforce zero tolerance.
- 9) Provide ongoing education to reinforce the organization's commitment to ensure a caring and respectful environment.
- 10) Lead by example and reward outstanding role models.

Schaffner, M., Stanley, K., Hough, C. (2005). No matter which way you look at it, it's violence. *Gastroenterology Nursing*. 28 (6), 75-76

Under-reporting of violent incidents against nursing staff.

This article challenges nurses to change the attitudes of nurses and the culture within the nursing profession toward violence and aggression in the clinical area, so that reporting incidents becomes the norm. It suggests that nurses:

- need to cast a critical eye over current practices to make the correct choice when considering whether to report incidents of violence or aggression
- need to ask why staff do not report incidents
- should not tolerate violent incidents in the clinical area nor passively fail to report incidents (a negative and dangerous approach)
- claim status and respect for their profession despite political, professional, historical and personal factors that can undermine this claim.

Ferns, T. (2006). Under-reporting of violent incidents against nursing staff. *Nursing Standard*, 20 (40), 41-45

Workplace incivility: State of the science.

The author introduces the concept of the incivility spiral: a framework to assess workplace incivility and target interventions to prevent its escalation into workplace violence. Important points to consider in the incivility spiral:

- 1) target's perception of initial uncivil act (e.g., a worker shouting at a colleague may not mean to cause offense, however, a person who does not consider this shouting to

- be a 'normal' behaviour may perceive this as an uncivil act.
- 2) potential at every interaction for departure from the spiral
 - 3) escalating nature of retaliation based on the perceived norm being violated (e.g., shouting at a construction site may be considered normal, while silence is expected at a library)
 - 4) tipping point occurs when workplace incivility becomes workplace violence: when the intent to harm is no longer ambiguous (e.g., when shouting that could be perceived as 'friendly' or 'normal' causes offense and escalates to a verbal or physical altercation).

Research indicates that incivility pervades workplace environments regardless of the setting. Employees expect managers to intervene. Collateral damage due to workplace toxicity causes an organization to become toxic. The research is lacking in determining what interventions at an organizational level can best manage incivility

Hutton, S.A. (2006). Workplace incivility: State of the science. *The Journal of Nursing Administration*, 36 (1), 22-28

Nurse abuse - what employers can do.

This article offers steps that employers can take to establish workplace environments in which nurses can feel confident to act should they experience an abusive situation, including to:

- 1) develop and make staff and clients aware of the zero-tolerance policies
- 2) develop clear procedures for reporting, investigating, and following up on all violent incidents
- 3) provide staff with the opportunity to express their feelings and relieve stress after violent incidents
- 4) provide access to appropriate resources to increase staff knowledge
- 5) supply appropriate resources to prevent abuse, including adequate staffing to meet client needs
- 6) establish a communication network for nurses who could experience abuse when providing care in clients' homes
- 7) assess the need for self-defense courses for staff
- 8) review room layouts in a facility so that 'escape routes' are available for staff.

College of Nurses of Ontario (2002). Nurse abuse – what employers can do. *Quality practice: A resource for employers of nurses*. 1 (6), 1,3

Safe environments: Accountability, clarity, education and teamwork.

The author presents strategies and frameworks that can be utilized by organizations in identifying and responding to aggression in the workplace.

Organizations can integrate the knowledge from these frameworks and develop effective intervention plans.

Strategies

- 1) Every workplace should have policies that demonstrate a strong commitment to the promotion and maintenance of a safe work environment, as well as include a clear definition of workplace violence.
- 2) These policies should guide daily practice and be highly disseminated.
- 3) HR policies should include:
 - a process for addressing violent behaviour, the consequences, and follow-up
 - when to involve security/police and how to obtain their assistance
 - management of after-hours entry
 - management of any weapons found.
- 4) Conduct an environmental assessment and identify opportunities to minimize risk (e.g., setting up offices to minimize the potential of being trapped without access to help; ensuring employees who interact with others around sensitive issues are not in isolated areas; and clearly defining an escape route for every office).
- 5) Communication plans for imminently dangerous situations should be explicit and include: who to call; what is to be said to convey the urgency of a situation; and what the expected response would be (examples should be provided).
- 6) Incorporate communication plan into employee orientation.

Frameworks

The Cycle of Aggression

This framework describes the stages of escalation in someone predisposed to the use of aggression to get their needs met, framed as a clock face:

12:00: stress and/or sense of loss generated

15:00: frustration, powerlessness and hopelessness lead to anxiety

18:00: anxiety converts to anger

21:00: threatening/assault behaviours used to discharge the anger and regain control

21:00–24:00: a sense of relief and decrease in anxiety reinforces the behaviour

Risk factors for someone predisposed to aggression:

- failure to respond to constructive advice, and blaming others for errors, mistakes or problems

- communicating unrealistic demands
- difficulty relating to others, decrease in productivity, concentration problems, under the influence of alcohol/drugs

If risk factors are identified it is important to communicate concerns to others and develop a plan.

The Self-Awareness Model

This framework:

- describes intrapersonal processes that can impact an individual's ability to respond effectively in threatening situations
- assists in recognizing an individual's predisposition to react to specific or generalized stressors that elicit anxiety, such as direct verbal or physical threats

Fight or Flight Reaction

To identify and understand triggers that precipitate personal reaction to stress follow these steps:

Get centered – use a body stance that is non-threatening to assist in helping you feel more centered

Tense/relax – tension is contagious: maintain a calm, responsive expression and tone of voice to help diffuse situation

Psychological time vs real time – take a moment to clearly assess a situation and depersonalize it

Farley-Toombs, C. (2006). Safe environments: Accountability, clarity, education and teamwork. *The Voice of Ambulatory Care Nursing*, 28 (1), 1, 10-12.

The enemy is not us: Unexpected workplace violence trends.

The authors offer solutions and initiatives that can reduce violence in the workplace based, in part, on what employees suggested in a survey. For example:

- restricting areas that are accessible to customers
- limiting the amount of cash on hand
- establishing and monitoring security systems
- increasing visibility around buildings (e.g., modify landscaping, improve lighting).

In organizations where employees routinely deal with angry customers it would help to establish a progressive system of 'discipline' in which employees are permitted to:

- issue warnings when angry outbursts occur
- ask customers to leave the establishment
- exit the scene of an angry customer outburst
- call security personnel or police.

Hoobler, J., & Swanberg, J. (2006). The enemy is not us: Unexpected workplace violence trends. *Public Personnel Management*, 35 (3), 229-246.

Boardroom bullying.

This article asserts that workplace violence results in significant personal and organizational costs. These costs can be reduced or eliminated through a comprehensive workplace violence prevention program. The authors suggest that progressive employers are implementing these programs to meet their emerging legal obligations and to reduce liability.

The Canadian Initiative on Workplace Violence offers the following framework to minimize the risk of workplace violence:

A) Violence Prevention Policy

Every organization should develop a violence prevention policy and put it in writing. This document should become the foundation for a violence prevention program. At a minimum the policy should:

- communicate the organization's commitment to preventing workplace violence
- provide an overview of its violence prevention program
- establish clear standards of behaviour that apply to all employees, managers, contractors and clients

B) Risk Assessment

To be effective in preventing workplace violence, employers must understand what risk factors are within their workplaces. A risk assessment then builds on this general understanding and includes input from both management and employees. The risk assessment should identify the most significant concerns for an organization.

C) Prevention Measures

Develop specific measures to eliminate or minimize risks identified in the risk assessment. Preventive measures can include training and education, and improvements to workplace design, administrative practices and work practices

D) Reporting and Investigative Procedures

Research shows that workplace violence is frequently under-reported. Every workplace should have a clearly defined system for reporting, recording, and investigating incidents or possible incidents of violence. The credibility of any violence prevention program depends, in part, on how quickly and effectively reports are handled.

Because workplace violence investigations may have serious legal consequences they should only be assigned to those with the appropriate skills, experience and authority. Many organizations are now considering creating special teams to investigate reports of workplace violence.

E) Emergency Response Plan

From an individual or organizational perspective, a specific plan that clearly outlines how to respond to a serious incident before it happens is essential. This plan should be comprehensive enough to deal with most incidents but easy enough to understand and remember.

F) Victim Assistance Program

Progressive organizations take the opportunity to immediately follow up on incidents, to demonstrate their concern for victims and to implement effective, comprehensive responses to violence. These programs may be available through an employee assistance program provider.

G) Incident Follow-Up

Incident follow-up should occur some time after the incident has been investigated and recommendations made. All incidents should be classified according to key characteristics such as similarities or common patterns. Incident follow-up should be part of an organization's ongoing effort to assess risk and improve prevention and response strategies.

H) Training and Education

Training and education are indispensable parts of any violence prevention program. The exact content and type of training depends on the results of a risk assessment and workplace-specific prevention program. At the very least, all employees should be familiar with the organization's violence prevention policy.

I) Program Reviews

Routine program reviews are critical in meeting organizational and employee needs. Ensuring that a program is current and responsive is a testament to an organization's commitment to a safe workplace.

French, G., & Serman, L. (2007). Boardroom bullying. *Canadian Healthcare Manager*, 14(1), 12-14.

Additional information can be found at:

http://www.chmonline.ca/issuearchive/Feb2007/contents_feb07.pdf
<http://www.benefitscanada.com/content/legacy/Content/2002/02-02/stress.html>

Assessing the risk of workplace violence.

A violence risk assessment tool can uncover risks for violence in a workplace. It is in the best interests of all employers to conduct an assessment and use best practices to avoid the impacts of violence.

In Nova Scotia, all employers have an obligation to make sure all workers have safe working environments. Assessing the Risk of Workplace Violence is a document available from the Nova Scotia Department of Environment & Labour. This document can be downloaded from <http://www.gov.ns.ca/enla>

Nova Scotia Department of Environment & Labour, Occupational Health and Safety. (2007). *Assessing the risk of workplace violence*. Halifax, NS: Author.

A 15-minute e-learning course entitled ‘Violence in the Workplace: Awareness’ is also available through the Canadian Centre for Occupational Health and Safety: http://www.ccohs.ca/products/courses/violence_awareness/

Nursing workforce retention: Challenging a bullying culture.

The existence of a bullying culture needs to be recognized and challenged before strategies can be effective. In nursing, it is up to senior nursing leaders to make this happen.

For example, when issues were raised in one Australian hospital, nursing management responded promptly to the issues raised by:

- 1) convening a workshop, and confronting behaviour that was acknowledged by most as having been around a long time but never discussed
- 2) taking responsibility, as appropriate, for the situation and reaching consensus to bring about change by developing, publishing and implementing their strategies
- 3) involving the next level of nursing management (nursing supervisors) in the problem-solving process
- 4) having senior nursing leader address each workshop, explaining her feelings and response to the research findings and asking groups for their help
- 5) implementing new strategies developed at workshops
- 6) developing a policy document on bullying and intimidation
- 7) developing statement describing exactly what constitutes bullying – so staff can recognize that this behaviour is problematic
- 8) acknowledging the existence of bullying behaviour throughout the organization – attempting to bring this behaviour out into the open without assigning blame and with a focus on changes for the future

- 9) supporting the development of role models for potential nurse leaders by:
 - equipping nurses coming into the facility with education and skills to resist and tackle bullying
 - incorporating skills to manage intimidation by staff into the role and competencies of nurse managers
- 10) providing nursing supervisors with training in performance management and conflict resolution: senior nursing leader scheduling 'ward time' into each work day.

It also should be noted that nursing leaders can tackle a culture of intimidation by:

- 1) developing more open communication and increasing access to nursing senior management
- 2) ensuring nursing supervisors receive adequate non-clinical training for their role
- 3) ensuring competency standards referring specifically to managing bullying and maintaining standards that are maintained through effective performance management
- 4) providing accessible professional development opportunities for all staff
- 5) developing policies on bullying in the workplace and conflict resolution mechanisms.

Stevens, S. (2002). Nursing workforce retention: Challenging a bullying culture. *Health Affairs*, 21(5), 189-193.

Creating a violence free workplace: Recognizing and responding to bullying in the workplace.

Managers who use a consistent style and are fair, thorough and non-aggressive will have the most success in stopping bullying behaviour. For targets, it is helpful to collect as much documentation as possible and to have witnesses. All this will help with investigations and highlight any patterns of behaviour.

In addition, healthy organizations:

- deal with bullying as quickly and effectively as possible
- do not tolerate abuse from anyone – the public included
- properly investigate complaints – and bullies are reprimanded or disciplined
- use feedback to improve quality of service
- take action whenever anyone is violent towards staff
- take measures to protect staff
- are sensitive to staffs' emotions and physical needs
- assist in recovery after incidents – securing an investigation team that is unbiased; ensuring no conflict of interest (may have to go outside the organization: no manager should

investigate their own staff); determining what the issue is and rebuilding confidence

- take steps to restore an organization's well-being
- develop a violence prevention plan – that includes addressing bullying behaviours
- train managers to investigate incidents using a process that is transparent, with relevant follow-up (invite union reps to take part in this training).

Three things must happen in order to change a culture that supports bullying. All individuals (including management and staff) must:

- be aware of what bullying looks like (before handing out an anonymous survey, educate staff about bullying behaviours)
- complete a risk assessment to determine the level of bullying behaviour in the workplace
- attend a workshop designed to educate everyone about bullying behaviours

To ensure an organizational shift and change in culture that supports bullying, organizations must also develop zero-tolerance workplace violence policies and implement strategies to ensure that the policies are followed. In a nutshell, employers must recognize the early warning signs of bullying behaviour (e.g., people should not be crying at work, calling in sick, throwing up before coming to work).

- 1) Employers need to ensure a violence prevention plan is in place that includes knowledge of what bullying is, and how to diagnose a problem and move forward with change.
- 2) To break the cycle of bullying, organizations must deal quickly with problems that cause frustration, anger and interpersonal difficulties. They must resolve conflicts quickly, and use Alternative Dispute Resolution (ADR) methods and mediation, but only if both parties are committed to it. Often bullies want the bullying behaviour to end - they just don't know how to stop the cycle. Reach out to the bullies too, however, if they don't want help let them go. Offenders must be disciplined.
- 3) Change the dynamics and organization culture by offering support to and empowering targets – recommend employee assistance plans (EAP). Remember, there is a risk for those (targets) counselled to confront their bully(ies).
- 4) Create a system for investigating, documenting and addressing conflicts.
- 5) Examine and remedy complaints swiftly and thoroughly.
- 6) Provide an uncomplicated and risk-free manner in which to privately lodge bullying concerns, regardless of a bully's

- role in the organization (e.g., whistle-blower legislation).
- 7) Conduct an anonymous 'Bullying in the Workplace' survey that asks questions specifically about individual experiences of common bullying tactics. This should be developed by an external entity.
 - 8) If a bully becomes physical, aggressive or threatening the organization needs to call the police. Be careful how this is done. If you call the police, the bully may threaten you or your family. Consider whether this person will harm someone else.
 - 9) If psychological or physical threats are made, call the respective regulatory body.
 - 10) Use of progressive discipline with a bully is determined on a case-by-case situation and by the impact on the individual. It may be appropriate that the individual be terminated without progressive discipline.
 - 11) Assessing survey results, implementing change and evaluating change will take approximately two years.
 - 12) Exit interviews are very important for gathering information. They should be conducted either at the time of an employee's departure, by an alternate manager, or six months after the employee's departure – to avoid jeopardizing or impacting new job opportunities for the employee. Keep track of all statistics.
 - 13) An anti-bullying policy must be enacted and applied to everyone – administrators, managers, staff (FT/PT/casual/contract), clients or customers and suppliers.
 - 14) Objectives for an anti-bullying policy should:
 - define workplace bullying
 - promote awareness of the issue among staff
 - provide an effective procedure for dealing with allegations of bullying (similar to a harassment policy)
 - include a statement of commitment
 - promote the rights of staff
 - create an environment of respect
 - expect a high standard for staff to staff interaction
 - educate all staff about bullying
 - outline a process for investigations
 - ensure all parties are aware of their responsibilities when witnessing, suspecting or hearing about bullying.

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Appendix - Learning Activity Answers

Module 1: Facts about Workplace Violence

Learning Activity 1

- 1) The foundation for a healthy work environment is one that is free of violence and where all staff members have a genuine respect for one another.
- 2) Individuals and organizations can work together to raise awareness, educate people and implement strategies to create and maintain safe, violence-free workplaces.
- 3) Damaging behaviours include: abusive language, condescending communication, witnessing or experiencing verbal abuse, physical abuse, threats and threatening behaviour.

Learning Activity 2

- 1) Individuals, including registered nurses, who work with vulnerable populations, work late hours, and/or who handle money report the most violence in their workplaces.

Learning Activity 3

- 1) Workplace incivility is distinct from workplace violence in that the intent to harm is ambiguous in the former.
- 2) Response could include: examples of workplace incivility; results in death for 1000 people/year; present in urban and rural areas; no relationship between gender and civility; toxic work environment; creates a culture of rudeness; affects quality of care; potential long-term consequences.

Learning Activity 4

- 1) Any of the following: staffing patterns, shift work, demanding workloads, poor security, and interventions requiring close physical contact; organizations with cultures that support behaviours of violence; rationalizing episodes of violence occurring within the practice environment; psychosocial and socioeconomic influences; personally stressful issues such as death, grief, divorce and being a victim of violence; the presence of illness often causes stress in patients, families and personnel; being a victim of violence can be related to an individual position and role in the healthcare system or can be a consequence of a nursing philosophy (e.g., primary care); interpersonal variables such as specific occupations, number of years experience, education level, relationship to the perpetrator of violence and work location.

Learning Activity 5

- 1) Any of the following: 25% of bullied individuals leave their jobs and are at risk for post-traumatic stress disorder, premature death, suicide, homicide, depression, heavier smoking, excessive drinking, drugs, overeating and loss of relationships; loss of self-confidence, self-esteem, sense of worth, belief in competency, feeling demeaned, inadequate, helpless and physically ill; suffering for 4-5 years from PTSD sometimes without recovery; a 'ripple effect'

on witnesses and a victim's family; high rates of sick time usage, absenteeism, lowered morale, loss of productivity, increased staff turnover, increased sick leave, additional recruitment costs, payouts, legal fees, and nurses leaving the profession; additional costs to employers may relate to restoring property, extending psychological care for employees, heightening security, and repairing a battered public image; staggering financial costs for organizations, and loss of faculty in the university setting due to 'victim blaming'.

Module 2 - Is Your Organization at Risk? Are You at Risk?

Learning Activity 6

- 1) Any of the following:
 - 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 or 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
 - stressors created by authoritarian managers, negative personalities and work overload
 - employees who have high public contact jobs
 - working with vulnerable populations, working late hours, or handling money
 - those who witness violence
 - healthcare providers
 - employees

Learning Activity 7

- 1) Workforce variables that influence whether incidents are reported: fear of retaliation from co-workers; the onerous process in reporting incidents; a perception of 'rocking the boat'.
- 2) Any of the following: prefer to deal with violent incidents informally, use of indirect aggression is the norm, fear of recognizing violence in own personal life, self-blame, domestic violence, childhood sexual or physical abuse, passive acceptance that violence is part of the job, a lack of professional autonomy, reporting to non-nursing managers, lack of power in the workplace, lack of conflict resolution training, low valuation of self, fear of being labeled incompetent or blamed for an incident, trying to put the patient first.
- 3) Suggested strategies:
 - Accurate data collection is the first step in developing strategies to minimize violence since

under-reporting influences research findings and as a result shapes policy.

- In-depth investigations are required to minimize assaults against nursing staff.
- Strategies aimed at encouraging nurses to report incidents require a public health approach that is not confined to health care.
- Violence, particularly against women, should be addressed by nursing leaders, researchers and educators.
- Since women dominate the nursing profession they are in a unique position to lead this area of policy development in minimizing violence in the home and at work.
- A robust reporting strategy must be implemented so that nurses can review current practices about making the correct choice when considering whether to report incidents of violence or aggression.

Also check 'Strategies' module in this resource, p. 57

Module 3 - Types of Workplace Violence

Learning Activity 8

- 1) Threatening Behaviour, Verbal Abuse and Physical Assault, Bullying
- 2) A threat is defined as 'a written or oral communication that implicitly or explicitly states a wish or intent to damage, injure, or kill the target'. It is a criminal act that is intended to inflict harm on an individual.
- 3) The majority of those making threats in health care are male. Most cases involve a target and a threatener of the same race.
- 4) A threat should never be disregarded, however it is made. Even if a risk is small that a threatener will actually carry out a threat, it is wise to put the necessary precautions in place. The prevalence of threats is high, and the danger of being threatened is increasing. Threats account for a high proportion of reported assaults, and management should be proactive and immediate in their response.
- 5) It is the responsibility of employers to ensure that relevant policies, procedures and education are in place to support employees faced with threats. Healthcare organizations must develop a mechanism for staff to report threats. It is suggested that hospital teams conduct periodic reviews of threats received, the management of threats, and case outcomes. Analysis of threats can include:
 - assessing and evaluating the level of danger or potential threat
 - developing investigative techniques and strategies
 - helping to identify offenders (threateners)
 - considering the way a threatening message is delivered, content and style, level of victim risk
 - initially treating all threats as potentially high risk
 - assessing why victim is being threatened and the danger level of threatener
 - assigning a risk level, allowing for implementation of an appropriate intervention.
- 6) Interpersonal training for employees at risk of receiving threats is crucial. This training ensures that employees know what they can and should say to a disgruntled customer; that they can recognize when it is in their best interests to exit charged situations or to call in another employee; training should include listening skills and conflict negotiation/avoidance tactics designed to detect and defuse potentially dangerous encounters; employees need to have easy access to the mechanism for reporting threats and know how to deal with violent and potentially violent situations.

Learning Activity 9

- 1) Nursing literature suggests nurses working in critical care, mental health, and emergency rooms are particularly vulnerable to physical violence, threatening behaviour and verbal abuse.
- 2) The term 'disruptive behaviour' describes personal conduct, whether verbal or physical, that affects or could potentially affect patient care negatively and is anything that interferes with good and safe patient care in any way.
- 3) Physical intimidation and violence: can include extreme behaviour such as throwing objects, pushing co-workers, tantrums, or yelling directly in someone's face.

Unpleasant and abusive behaviour: includes demeaning others through overt sarcastic remarks and encompasses covert actions and statements that undermine co-workers professionally.

Refusal to cooperate: refusal to follow directives, cooperate with group decisions or accept input is a behaviour pattern that can adversely affect patient care. An example could be a nurse who knows it all and won't listen to anyone else.

- 4) a) False b) True c) True
d) True e) True f) False

Learning Activity 10

- 1) Workplace bullying is deliberate, with an ongoing array of often subtle and masked negative behaviours and actions that accumulate over time. It is experienced as gradual, cumulative, often hidden and intensely harmful experiences. Bullying is described as unrelenting, calculated, and deliberate causing psychological harm, physical illness and eventually resulting in an inability to work.
- 2) Examples
 - a) RN who ignores a new graduate's request to review a procedure before performing it on a patient.
 - b) Two RNs roll their eyes and make snide remarks in a staff meeting when another RN is asked to clarify a new policy.
 - c) A physician yells at a nurse over the phone when called at night regarding a patient's status .
- 3) In organizations, bullies are deemed responsible for lowered morale, reduced productivity, increased staff turnover, and increased sick leave. They are also responsible for nurses leaving the profession. The results of bullying can cost individual organizations thousands of dollars, and collectively – billions.
- 4) Individually, victims report leaving their jobs, experiencing anxiety, depression, loss of self-confidence, self-esteem, sense of worth, and belief in their competency. They feel demeaned, inadequate, helpless and physically ill. They are at risk of post-traumatic stress disorder, premature death, suicide, homicide, heavier smoking, excessive drinking, drugs, overeating and loss of relationships. Witnesses to bullying behaviour report feeling sorry for the victim, increased stress levels, worrying about becoming a victim, fearful of taking action, changing jobs to avoid the problem, working harder in the hope of not becoming a victim or joining in with the bullying.

- 5) Negative effects resulting from group bullying include nurses changing jobs, working under negative patterns of control, resignations, suicide, and acceptance of behaviour by senior staff in the workplace.
- 7) Bully defined 'rules of work' make individuals feel powerless if not on the side of the bullies, newcomers are welcomed to the workplace by being bullied into submission, individuals experience subtle forms of exclusion, hide their competence and capability by appearing insignificant and feel unreasonably dominated in the workplace.
- 9) a) False b) False c) True d) True
- 10) Research shows that males and females are equally responsible for bullying behaviour.
- 11) Strategies could include:
 - the development of evaluation tools to test whether current or potential employees have a tendency to bully others
 - administering an assessment tool to determine if bullying behaviour exists in the workplace and to increase awareness of bullying behaviour
 - a code of practice governing conduct in the workplace may help shift organizations from confrontational to cooperative cultures – use of a problem solving rather than punitive approach and the development of critical leadership skills to have difficult and courageous conversations – especially managers.

As individuals, nurses must take responsibility in eradicating bullying behaviours. Evidence is mounting that nurses are both perpetrators and targets of workplace violence and need to confront these behaviours, challenge them and eradicate them.

