Reducing the risk of violence towards remote area nurses: A violence management toolbox

Kylie M. McCullough, BSc (Hons) (Nursing), Sue Lenthall, MPH&TM, Anne M. Williams, PhD, and Lesley Andrew, MSc BSc (Hons)RN RHV

Clinical Nursing and Midwifery Research Centre, School of Nursing and Midwifery, Edith Cowan University, Joondalup, Perth, Western Australia and Centre for Remote Health, Alice Springs, Northern Territory, Australia

Abstract

Objective: To explore the knowledge of a panel of experts to develop possible ways of minimising the risk of occupational violence towards remote area nurses.

Design: The Delphi method using open-ended questionnaires and an online survey to measure support for suggested control measures.

Setting: Remote area nursing posts across Australia.

Participants: A panel of expert remote area nurses (n = 10) from geographically diverse regions.

Main outcome measure: Identified and described measures with the potential to reduce the risk of violence.

Results: A ‘toolbox’ of strategies was suggested in recognition of the complex nature of occupational violence within the remote health context. Job-specific education included de-escalation techniques, risk assessment and cultural safety training. Professional support included access to counselling and debriefing services. Organisational responsibilities included: adequate staffing to provide backup, policies and procedures and action from management when hazards are identified. Community collaboration with the health service in developing orientation programs, safety plans and addressing violence within the community was also recommended.

Conclusion: A variety of strategies were identified that could be used to reduce the risk of occupational violence towards remote health care staff. Further development and assessment of this ‘toolbox’ of strategies is recommended to address the high incidence of violence towards remote health professionals in Australia and overseas.

Key words: Delphi method, occupational violence, risk management.

Introduction

Remote area nursing practice is characterised by living and working in isolated communities with complex health needs. Remote area nurses (RANs), either individually or in small groups; often with Aboriginal health workers, are responsible for providing and coordinating health care services for remote communities. RANs are mostly women, often working alone during after-hours consults and home visits, and are almost universally required to provide after-hours medical assistance. The self-reported incidence of violence towards RANs seems to have increased over the last 13 years, with violence identified as a significant stress or, contributing to staff turnover.

This paper reports on the second part of a study that used a risk management approach to investigate violence towards RANs. The hazards identified in this study are reported elsewhere. The control measures identified by the study are reported here using a ‘toolbox’ analogy in recognition of the multifaceted nature of occupational violence and the need for a range of strategies to reduce the risk of violence towards RANs.

Methods

A panel of 10 expert RANs with an average length of service in remote health of 16.7 years (range 4–30 years) informed this study. Selection was based on extended length of practice as a RAN and involvement in the RAN community. A detailed description of the study is available elsewhere. Questionnaires were conducted via email and Internet survey and followed a three-round Delphi process. The Delphi method aims to distil expert knowledge and validate that knowledge by assessing consensus within the panel. Content analysis of data from the first round, open-ended questionnaire, and subsequent lit-
erature search, informed a survey which assessed agreement among the panel. In the survey, a Likert scale was used to assess the level of consensus and to indicate potential usefulness of each of the control measures. The scale responses were: not useful, useful, very useful or essential. Results were analysed using descriptive statistics. Consensus was determined as 70% agreement that the control measure was considered very useful or essential. Only measures that reached consensus are described here. Ethics approval was granted by Edith Cowan University.

Results
Four themes emerged from the data which provided suggestions for improving the safety of RANs. These were: Education and training; professional support; organisational measures and community collaboration.

Education and training
The panel agreed that education and training needs for RANs should include de-escalation techniques, self-defence techniques, recognition of symptoms of post-traumatic stress disorder and knowledge of how to assess the work environment for hazards. RANs also need specific clinical skills including how to conduct mental health assessments and create management plans in consultation with the family.

Cultural safety education which includes knowledge of relevant Indigenous culture, power relationships and influence of one’s own culture on interpersonal relationships was recommended. Passing on ‘corporate knowledge’, such as the history and politics of the health service and community, should be included in local orientation. Community members could be involved in the orientation of new staff.

Professional support
The panel identified that involvement in a violent incident can be traumatic, and access to debriefing by trained personnel was considered vital. Bush Support Services, a 24-hour telephone help line, was identified as a significant avenue for support. Additional support could be facilitated via a mentor program that was funded to provide training and support to the mentors and recognition of the additional time needed to participate.

Appropriate numbers and skill mix of staff are essential; this includes the abolition of single nurse posts. A second nurse on-call, as well as a police presence in all communities, was recommended by the panel. Frequently filling vacancies with inexperienced and under-qualified staff was noted to decrease the opportunity for professional support for experienced staff. Attempts by employers to reduce stress and increase job satisfaction might be evidenced by involvement in ‘employer of choice’ programs.

Organisational responsibilities
The panel agreed that employers have a responsibility to take action when concerns are raised. Several panel members provided examples of hazards that had been identified and not dealt with and incident reports that had been seemingly ignored. A check-in system and duress alarms were also recommended. Providing funding to address concerns and improving communication between managers and staff were considered high priorities.

Policies and procedures were perceived to lack RAN involvement, to be inflexible and unevaluated. This contributed to the panels’ belief that policies protected management rather than staff on the ground. ‘Zero tolerance to violence’ policies were considered essential, but the practical implementation of these policies, including consequences for violent behaviour, were seen as problematic. Employers should have policies that discourage RANs from attending intoxicated patients on their own or attending patients within staff residences.

Community collaboration
Community collaboration was seen as a vital aspect in managing the risk of violence in remote communities.

What is already known on this subject:
- Incidents of occupational violence against nurses are unacceptably high.
- RANs in Australia frequently encounter violence in the workplace and have limited resources to deal with the problem.
- Violence is a significant stress for RANs and appears to be on the increase.

What this study adds:
- This study provides suggestions that might reduce the risk of violence towards RANs from the viewpoint of an expert panel of RANs.
- The concept of a toolbox is introduced to encourage the adoption of a wide variety of strategies.
The establishment of a formal consultation process with the community that aims to: develop a safety plan, consider violence reduction strategies and consequences for violent behaviour, and develop a mutual understanding of service expectations was identified as important.

The panel described the components of, and barriers to, creating a safety plan. The plan should include procedures for obtaining help in an actual or potentially violent situation by listing reliable community contacts, possibly as night drivers; identifying safe area within the clinic and having a plan for evacuation of staff in extreme circumstances. The plan should provide guidance for behaviour in particular contexts for example; attending call-outs at night or travelling to particular areas. A process for prosecution of offenders and consequences for violent behaviour (such as restricting access for intoxicated clients) are additional considerations. The likelihood of RANs becoming involved in violence in the community was described by one panel member who stated, ‘the clinic staff are always present, have access to phones, speak English and can communicate with authorities – they nearly always end up being the people to go to for any crisis’.

The development and implementation of a safety plan might be hampered by a lack of interest from health centre staff, an employer’s slow response to issues raised and the potential for development to be a long process. The time and effort required to develop and implement a safety plan should be resourced so as not to put additional pressure on clinical staff.

Consultation and involvement with all stakeholders was identified as essential in developing a safety plan. Community acceptance of the plan might be a barrier due to unrealistic expectations, lack of trust, commitment and responsibility among the community and health service. Lack of volunteers willing to be contacts, uncertainty of who is in the community and potential problems for community members expected to enforce consequences might also hinder a safety plan. There might be a role for independent assessors or consultants to aid in this process.

Discussion

Strategies to improve the personal safety of RANs must be aimed at minimising the incidence, duration and severity of violent incidents. According to Viitasara and Menckel, primary prevention strategies are applied in everyday practice, secondary strategies are used when an aggressive or violent incident occurs and tertiary prevention strategies aim to prevent a recurrence of the event and minimise any ongoing distress to staff after a violent incident. The concept of a ‘toolbox’ recognises that complex problems like occupational violence require a variety of tools that can be adapted to different situations by staff with a range of skills and experience. Using this framework, Figure 1, was developed to summarise the control measures recommended by this study and occupational violence literature, within the context of violence towards RANs.

Primary prevention

The recruitment and preparation of skilled staff with ongoing support and reduction of the causes of stress are key components of a risk reduction strategy. Specific
preparation for the role of a RAN should include cultural safety, aggression management and communication skills. Additional training for RANs is recommended to include how to engage community support and participation in violence reduction strategies such as: safety plans, clinical management plans and community education programs as well as mental health assessment.

Single nurse posts have been identified as a hazard that increases the risk of violence towards RANs. The Council of Remote Area Nurses of Australia has identified that single nurse posts carry a high risk of ‘... professional isolation, fatigue and exploitation’. Abolition of these posts is recommended.

Mentoring programs should be established and well resourced. Mentoring is a relationship that exists to provide support, personal growth and an increase in professional role effectiveness. It is characterised by core qualities of confidentiality, honesty, sharing of information, enthusiasm and a commitment to an ongoing relationship. Mentoring programs must be formally recognised by management and budget holders. Suggested methods for establishing a program in remote areas include an initial training workshop, establishment of a mentor register and encouragement in the use of technologies such as email, Web-based discussion forums and regular telephone contact.

A comprehensive orientation program is vital to safe practice. Providing local orientation recognises the need to quickly gain knowledge specific to the culture of that community. Orientation of General Practice registrars in the Northern Territory has a strong focus on cultural safety and self-care. This model has applicability across disciplines and might be particularly useful for RANs. A comprehensive evaluation of current formal and informal orientation practices could produce guidelines to ensure the best preparation for new RANs.

Community involvement in health service provision is a key strategy to reduce the risk of violence. This includes participation in the recruitment, orientation and education of RANs. Addressing the wider issue of violence within remote communities might reduce the risk of violence towards RANs. Further research regarding community perspectives of health services and violence might reveal new strategies for improving communication and involvement.

Secondary prevention
When an aggressive incident occurs, training has been shown to prevent the escalation of violence. Techniques can be used to diffuse a situation and limit the duration and extent of a violent incident. De-escalation techniques such as empathy, clear communication skills, remaining calm and displaying respect should be included in preparation programs for RANs.

Risk assessment tools have been developed for use in emergency departments. These tools recognise the behaviours that might be a precursor to violence. Development of a tool to measure the potential for aggression could guide RANs in implementing extra precautions and requesting an escort to high-risk call-outs.

A safety plan must include: what to do in the event of an incident, who to call and when, and how to get to a safe place if needed. Developing a safety plan in consultation with the community and identifying local resources are featured heavily in the recommendations of the National Health and Medical Research Council. Building relationships with local councils, night patrols and the police might provide opportunities to discuss local issues and develop strategies to improve the safety of the whole community.

Providing backup support by ensuring there are adequate numbers of police and health workers in remote communities and having a paid escort or ‘second on-call’ are important strategies. Taking an escort has been recommended in the literature. However, fatigue might be a barrier when there are only a very small number of people who can be called on as an escort.

Tertiary prevention
Tertiary prevention and treatment of individuals after a traumatic experience includes access to professional counselling and support from colleagues and managers. Recognising the symptoms of post-traumatic stress disorder in themselves and others might help minimise the effects of violent incidents. Identifying support networks promotes self-care. The Bush Support Services program includes a telephone and Internet counselling service, education program, and links to other support services through their website.

The underreporting of occupational violence is well documented. Ensuring that RANs involved in a violent incident are considered victims of a traumatic event, rather than to blame, and challenging the prevailing attitude that violence is ‘part of the job’, might encourage reporting and action from employers.

Conclusion
Reducing the risk of violence towards RANs requires urgent attention from employers and communities alike. This study outlines a toolbox of strategies including: education, professional support, and organisational and community responsibilities, and frames them within the context of primary, secondary and tertiary violence prevention. Reducing the risk of occupational violence
might reduce staff turnover and the consequences of skill shortage in remote areas. Feeling safe at work is a basic right, and development and implementation of the strategies identified in this study are recommended to be a high priority for funding providers and researchers.

Acknowledgement

The researchers are extremely grateful to the expert panel for providing their time and expertise for this project.

Author contributions

Kylie McCullough: Study design, data collection, analysis and write-up of paper.

Sue Lenthall, Anne Williams and Lesley Andrew: Supervision of study, data collection and analysis; review and editing of final paper.

References


