2. Occupational stress in the remote area nursing profession

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International reviews have demonstrated high levels of occupational stress in various health and community service professions, including nursing (Bakker, Schaufeli & van Dierendonck, 2000; Dollard, LaMontagne, Caulfield, Blewett, & Shaw, 2007; Michie & Williams, 2003). Indeed, stress in nursing has been an area of considerable interest and research for almost half a century (Menzies, 1960). Decades of research documents a multitude of workplace stressors and their impact on various outcomes measures, such as productivity, quality of patient care and worker health and well-being.

There is some evidence that nurses, relative to other health professionals and human service workers, experience greater levels of occupational stress (Bakker, Schaufeli & van Dierendonck, 2000). Nurses also report greater levels of occupational stress, in comparison to other professional groups across the board (Chan, Lai, Ko & Boey, 2000). It must be noted, however, that the majority of nursing stress research has been conducted in hospital-based settings. Comparatively few studies have been performed in community-based settings, and fewer still in a very remote health care context.

Only recently is remote health receiving recognition as its own independent and clinically distinct area of practice. According to a comprehensive definition provided by Wakeman (2004, p.?), remote health

“...is an emerging discipline with distinct sociological, historical and practice characteristics. Its practice in Australia is characterised by geographical, professional and, often, social isolation of practitioners; a strong multidisciplinary approach; overlapping and changing roles of team members; a relatively high degree of GP substations and practitioners requiring public health, emergency and extended clinical skills. These skills and remote health systems, need to be suited to working in a cross-cultural context; serving small, dispersed and often highly mobile populations; serving populations with relatively high health needs; a physical environment of climatic extremes; and a communications environment of rapid technological change”.

Australians living remotely experience poorer health outcomes than those living in rural and regional areas (Australia Institute of Health & Welfare, 2008). They also demonstrate poorer health standards than their major city, or metropolitan, counterparts (Australian Institute of Health & Welfare, 2008). As a general population, remote Australians manifest higher death rates and lower life expectancy and have less access to health resources (Australian Institute of Health & Welfare, 2008). In remote and, in particular, very remote Australia there are few general practitioners to provide the necessary health services. Accordingly, most health service delivery is administered by small, collaborative health teams, with registered nurses and Indigenous health workers representing the majority of health professionals (Lenthall et al., 2011).

The term used to describe a nurse who works in remote areas of Australia is Remote Area Nurse (RAN). In delineating the role of RANs, The Council for Remote Area Nurses of Australia (CRANAPlus) Inc. provides the following definition (2003, p107):
Remote area nurses in Australia provide and coordinate a diverse range of health care services for remote, disadvantaged or isolated populations. Their practice is guided by primary health care principles and includes emergency services, clinical care, health promotion and public health services. Remote area nurses work in a variety of settings including outback and isolated towns, islands, tourism settings, railway, mining, pastoral and indigenous communities.

As specialist practitioners, RANs provide “continuous, comprehensive and coordinated health care” and undertake “appropriate educational preparation for their practice” (CRANA, 2003, p.107). Unlike nurses working in hospital-based settings who perform more consistently in acute areas of practice (Hegney, Pearson & McCarthy, 1997), nurses working remotely are required to use a broad range of clinical skills in response to varied client needs (Opie, Dollard, Lenthall, Wakerman, Dunn, Knight & MacLeod, 2010). Extended clinical skills are required in the provision of services such as primary health care, trauma, health promotion and disease prevention, accident and emergency, acute care and chronic disease management, as well as the provision of care for mental health issues, substance misuse, domestic violence and child abuse (Kelly, 1998).

Beyond the demands of extended health practice, remote area nurses are required to endure inadequate staffing levels, mandatory on-call duties and frequent overtime, professional isolation, violence in the workplace, limited supervision, concerns for personal safety, inadequate infrastructure or equipment and issues arising from inter-cultural factors (Opie et al., 2010; Lenthall, Wakerman, Opie, Dollard, Dunn, Knight, MacLeod & Watson, 2009; Yuginovich & Hinspeter, 2007; Kennedy, Patterson & White, 2003). Furthermore, remote area nurses are required to function under these conditions, whilst striving to meet the health demands of some of the most disadvantaged populations in Australia. Such conditions have the capacity to contribute to elevated levels of occupational stress (Willis, 1991), and are believed to be responsible for the issues surrounding remote area nurse retention (Kennedy et al., 2003). Estimates of staff turnover in remote areas range from 57% (Garnett, Coe, Golebiowska, Walsh, Zander, Guthridge, et al., 2008) to 300% per annum (Kelly, 1998). High staff turnover leads to inadequate staffing levels and increased workloads for the remaining nurses, contributing further to the occupational stress experience.

As previously mentioned, scant research has considered occupational stress in the remote area nursing population (for additional research see Albion et al 2005; Eley & Baker, 2007; Fisher et al, 1996; Hanna, 2001; Hegney et al, 2002a, 2002b; Kennedy et al., 2003; Lea & Cruickshank, 2005; Lenthall et al 2009; Opie et al., 2010a, 2010b; Yuginovich & Hinspeter, 2007).

In a literature review examining occupational stress among RANs, Lenthall et al identified four major sources of stress, including the remote context, workload and extended scope of practice, poor management and violence in the workplace and the community.

In earlier research, Kennedy et al. (2003) performed a needs assessment to identify factors affecting turnover of rural and remote health professionals. Self-report data revealed sources of job dissatisfaction and reasons for attrition, but of particular relevance were the most displeasing workforce factors for rural and remote nurses specifically. According to Kennedy et al. (2003, p.8), the most displeasing workforce factors included lack of staff, lack of management support, lack of financial resources, lack of continuing professional development, professional isolation, feeling undervalued, on-call hours, lack of time off/relief, and the availability and quality of accommodation. Eley & Baker (2007) have also investigated factors influencing the retention of rural and
remote health service providers, with findings indicating that issues of mental health care provision, accessibility of health services, community perception and interagency collaboration were most influential in decisions of resignation.

Furthermore, Dade-Smith (2004) explored factors impacting on the rural and remote nursing workforce. Results demonstrated that issues such as opportunities for professional development, availability of locum relief, possibilities for spouse employment, professional isolation, on-call demands, and family and schooling matters were most unsatisfactory. Similar to the recent findings of Lenthall et al. (2009), this research also demonstrated that concerns for personal safety were once again identified as presenting significant impact on this population.

Opie et al. (2010) only recently performed the first empirical analysis of occupational stress levels in the remote area nursing workforce, with findings demonstrating that nurses working in very remote Australia experience significantly higher levels of psychological distress and emotional exhaustion, compared with other professional populations, including human service workers, police officers, psychiatric nurses and ward nurses. The job demands most strongly associated with increased levels of occupational stress as assessed by emotional exhaustion and symptoms of post-traumatic stress disorder (PTSD) were: responsibilities and expectations, emotional demands, workload, the remote context and isolation, cross-cultural issues and culture shock, staffing issues, poor management practices, difficulties with equipment and infrastructure, and workplace violence. Discussion of these job demands can be viewed in Box 2.1

Workplace violence in the remote nursing profession has been the occupational stressor selected as the focus for this chapter. We shall now explore its nature and prevalence, and intervention strategies.

**WORKPLACE VIOLENCE: NATURE AND PREVALENCE**

Within the health care sector nurses have been found to be more at risk of exposure to violence than others (Findorff et al., 2004). The international Council of Nurses (ICN) (2007) report that nurses suffer from societal and legal tolerance of violence; nurses have been refused compensation on the basis that to practice nursing was to accept the risk of personal violence. Nurses themselves often feel that violence is ‘part of the job’ and that they are ‘legitimate targets’ (ICN, 2007).

Workplace violence has been identified as a contributing factor in remote area nursing turnover (Morrell, 2005). Fisher et al. (1995) investigated workplace violence in the remote area nursing workforce and documented that remote area nurses experienced “frequent and serious episodes of violence, with verbal aggression, property damage and physical violence the most common”. Furthermore, the researchers reported that remote area nurses in small communities experienced more workplace violence than their metropolitan counterparts. Specifically, 86% of respondents had experienced aggression, and 43% of respondents had experienced abuse. In light of these findings, Kelly (1999) argues that, as a result of increased exposure to violent or traumatic incidents in the workplace, remote area nurses are at a greater risk of developing conditions such as post-traumatic stress disorder (PTSD). It has also been argued that there is an increased susceptibility to anxiety, impaired professional function and difficulties sleeping (Rippon, 2000; Robbins et al., 1997; Fisher et al., 1995).

In an effort to build on existing empirical and anecdotal evidence and to determine
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BOX 2.1 JOB DEMANDS MOST STRONGLY ASSOCIATED WITH INCREASED LEVELS OF OCCUPATIONAL STRESS FOR REMOTE AREA NURSES

Responsibilities and Expectations
There is a feeling among RANs that the community and health service have unrealistic expectations and that they, themselves, cannot meet the demands arising from both the community and the health service. This is often exacerbated by the advanced practice role that RANs are required to perform without adequate professional preparation.

Emotional Demands
Any job that entails working with people has emotional demands. The poor health of Indigenous peoples, the frequency of emergencies, and the regularity of a pre-existing relationship or association between the RAN and client can add weight to the emotional demands of RANs. The issue of emotional demands and their relationship with burnout is considered extensively within the work stress literature.

Workload
The sheer volume of work is a major issue for RANs, with long working days and higher morbidity rates in many communities. The ‘frontline’ nature of remote area health work and the lack of medical and allied health presence dictate that nurses are subject to greater workloads, including frequent on-call responsibilities.

The Remote Context and Isolation
Working in isolation is the most pervasive feature of remote area life (Willis, 1991). Isolation extends beyond geography to encompass social and professional life. In particular, the social support provided by family and friends is less accessible.

Cross Cultural Issues and Culture Shock
Most RANs work in remote Indigenous communities and face a range of challenges relating to cross-cultural environments. These include differences in language, social norms and gender roles, disparity in religious and spiritual practices, and contested values and beliefs relating to health and illness (Wakeman & Lenthall, 2002).

Staffing Issues
Recruitment of adequate staff is often difficult in remote areas. Many remote clinics have vacancies or have positions that are temporarily filled with short term agency staff. This situation decreases the capacity of clinics to provide staff with time off for in-servicing or annual leave. The increase in short term temporary staff (who have often been poorly orientated) adds to an existing burden of stress for the longer term nursing staff.
Poor Management Practices
Poor management practices in remote health, including lack of management support, constitute a further issue that has been highlighted. These poor practices are compounded by the distance most managers are from the RAN workplace and the limited number of health clinic visits.

Difficulties with Equipment and Infrastructure
Vast distances also impact on the difficulties experienced with equipment and infrastructure. There is generally inadequate housing for RANs which is further compounded by the cost of building in remote areas and the often poor building that happens. To get a piece of equipment repaired is often difficult and time consuming. Issues with equipment and infrastructure cause a great deal of frustration for RANs.

Workplace Violence
Concern for personal safety and the witnessing and experience of workplace violence has also been reported as a significant workplace stressor for the remote area nursing population (Dade-Smith, 2004; Lenthall et al., 2009; Opie et al., 2010). Whether the incidence of violence against remote area nurses has changed over time, Opie et al. (2010) assessed the frequency of various forms of workplace violence and compared their data to that obtained for the Context of Silence Report (Fisher et al., 1995). The researchers further examined the various forms of workplace violence and their relationships to posttraumatic stress disorder (PTSD) symptoms.

Three hundred and forty-nine (349) nurses working in very remote Australia participated in their study. In the 12 months preceding survey completion, the form of violence most commonly experienced by remote area nurses was verbal aggression (79.5%), followed by property damage (31.6%), physical violence (28.6%), sexual harassment (22.5%), stalking (4.9%) and sexual abuse/assault (2.6%). These results represented incidents of workplace violence that were specifically experienced by remote area nurses only. These figures did not include the witnessing of violent incidents that were directed towards remote area nurses’ co-workers, family, friends or other members of the community. Results further indicated statistically significant positive correlations between all types of workplace violence and PTSD symptoms.

Results from their study also demonstrated that in the 12 months preceding survey completion, the type of violence most frequently witnessed by remote area nurses towards others was also verbal aggression (85.7%). The next most frequently witnessed types of violence towards others were physical violence (57.9%), property damage (53.9%), sexual harassment (32.1%), stalking (14.3%) and sexual abuse/assault (10.9%). Statistically significant positive correlations were found between each type of witnessed violence and PTSD symptoms, excluding sexual abuse/assault which was found to have to have no relationship to PTSD symptoms.

Table 1.
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**Table 2.1 Media Coverage of the incident on Mabuiag Island, in the Torres Strait**

<table>
<thead>
<tr>
<th>Date</th>
<th>Title</th>
<th>Publisher</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. “Threat to raped Torres Strait nurse was ignored”</td>
<td>2. News.com.au</td>
</tr>
<tr>
<td>5 Mar 2008</td>
<td>1. “Nurse’s pay cut over ‘work injury’ rape”</td>
<td>1. The Australian</td>
</tr>
<tr>
<td></td>
<td>2. “Government apologises over nurse rape”</td>
<td>2. Brisbane Times</td>
</tr>
<tr>
<td></td>
<td>3. “Government ‘sorry’ for raped nurse’s pay issue”</td>
<td>3. The Age</td>
</tr>
<tr>
<td>10 Mar 2008</td>
<td>“Desperate hours of island rape victim”</td>
<td>The Australian</td>
</tr>
<tr>
<td>12 Mar 2008</td>
<td>1. “Torres Strait not safe for nurses”</td>
<td>1. ABC News</td>
</tr>
<tr>
<td></td>
<td>2. “Security boost after island rape”</td>
<td>2. The Australian</td>
</tr>
<tr>
<td>14 Mar 2008</td>
<td>“Torres Strait nurse to sue Govt over alleged rape”</td>
<td>ABC News</td>
</tr>
<tr>
<td>17 Mar 2008</td>
<td>“Renewed pressure on Robertson over alleged nurse rape”</td>
<td>The Courier-Mail</td>
</tr>
<tr>
<td>10 Apr 2008</td>
<td>“Ads add insult to injury after Torres Strait nurse rape”</td>
<td>News.com.au</td>
</tr>
<tr>
<td>26 May 2008</td>
<td>“Torres Strait nurse safety review nearing end”</td>
<td>ABC News</td>
</tr>
<tr>
<td>6 Aug 2008</td>
<td>“Govt promises impartial nurse rape investigation”</td>
<td>ABC News</td>
</tr>
<tr>
<td>23 Oct 2008</td>
<td>“Torres Strait nurses evacuated after threat”</td>
<td>The Courier-Mail</td>
</tr>
<tr>
<td>26 Feb 2009</td>
<td>“Nurse rape report dominates Qld campaign”</td>
<td>The Age</td>
</tr>
<tr>
<td>27 Feb 2009</td>
<td>“Health Officer and staff in trouble on nurse’s rape”</td>
<td>The Australian</td>
</tr>
<tr>
<td>18 Aug 2010</td>
<td>“Nurse slams rapist’s jail sentence”</td>
<td>The Australian</td>
</tr>
</tbody>
</table>

In the comparison of findings from their study to the findings of Fisher et al. (1995), Opie et al. (2010) reported that there had been statistically significant increases in the frequencies of physical violence, stalking, property damage and aggression. There were also increases in the incidence of sexual harassment and sexual abuse/assault; however, these were not significant.

In light of this research, it may come as no surprise that the safety and well-being of remote area nurses is not a foreign concept in the media. In 2008, for example, an alleged rape of a remote area nurse on Mabuiag Island, in the Torres Strait, received significant media coverage, public discussion and political attention (Australian Broadcasting Corporation, 2008; news.com.au, 2008; Queensland Government, 2008; Queensland Nurses’ Union, 2008; The Australian, 2008; The Courier Mail, 2008; The Queensland Health Ethical Standards Unit, 2008; The World Today, 2008; Torresnews.com.au, 2008). According to various media reports, on the night 5 February 2008, a 22 year old man broke in to the home of the 27 year old nurse. He allegedly raped her and burgled the property. The nurse had been working in the single nurse clinic on Mabuiag Island as an employee of Queensland Health for only three weeks.

Unfortunately and inexcusably, it appears this alleged rape could have been avoided. A 2006 Risk Assessment Report, submitted to Queensland Health, identified a number of existing security risks to the nurses. Risks relating to employee accommodation were described as “extreme”, with urgent warnings and recommendations for safety upgrades. The report highlighted problems with telephone contacts, inappropriate lighting, locks, doors and windows, amongst other security features on accommodation used by the nurses. It described the state of building maintenance as “inadequate” and recommended that the significant risks to staff be addressed immediately. Regrettably, these
reviews were reportedly not acted on, despite the government’s awareness of the security and safety concerns facing the nurses in this region.

According to The Australian (10/3/08), such shocking working conditions “are typical of the types of trauma faced by nurses who work alone in communities where there is no doctor and no police officer, and no help from the community...” Somehow, despite various taskforce recommendations and zero tolerance policies that have been established in response to workplace violence in the nursing profession, incidents such as this one continue to occur.

PREVENTION AND MANAGEMENT OF VIOLENCE

The risk of violence towards RANs cannot be completely eliminated as their job involves interactions with people in often stressful or highly charged situations. Therefore, strategies to improve the personal safety of RANs must be aimed at minimising the incidence, duration and severity of violent incidents (Viitasara & Menckel, 2002). Brooks, Staniford, Dollard and Wiseman (2010) propose a model as shown in Figure 1 for the prevention of work related violence and aggression. They highlight multiple levels of intervention that might underpin prevention. We use their framework to propose intervention levels and strategies for the reduction of violence and aggression in remote area nursing workforce.

1. Support Strategies

Public awareness
In remote communities, ownership of, and active participation in the health service by community members can be positive strategies for reducing violence towards RANs. Unrealistic community expectations of the nurse have been identified as a source of occupational stress (Opie et al, 2010), and negotiating the nurse’s role and community expectations can reduce this stress and reduce the potential for conflict. A sense of ownership of the health service, by the community, may also act as a protective factor. Community members should be involved in the recruitment, orientation and training of staff, as well as the development and implementation of strategies to reduce violence.

Negotiations with senior police and local police are also necessary to ensure adequate prevention and response to incidents of violence towards RANs. With the geographical isolation and the absence of resident police officers in some remote communities, there have been occasions where police have not responded to violent incidents against nurses. This has often been exacerbated by bans on overtime or limited resources. These issues need to be addressed.

Organisational culture and climate
Whilst the issue of workplace violence in the remote area nursing workforce has been acknowledged and responded to at a policy level, the organisational culture of many organisations still do not seem to take these policies seriously.

The Australian Nursing Federation (ANF) (2008) stipulates that “nurses and midwives have the right to expect that employers will implement policies and procedures supporting a zero tolerance approach to occupational violence and aggression”. The
Table 2.2  CPPT Model of Intervention Layers for the Prevention and Management of Aggression

<table>
<thead>
<tr>
<th>Level</th>
<th>Aim</th>
<th>Strategy Areas</th>
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</thead>
<tbody>
<tr>
<td>SUPPORT</td>
<td><strong>CULTURE</strong></td>
<td>Gaining community support through development of a communication and public awareness campaign with a variety of partners such as the police, media, and victim support centres.</td>
</tr>
<tr>
<td>STRATEGIES</td>
<td></td>
<td>Creating and maintaining an organizational climate that supports the goals of the anti-violence program by using principles of organizational justice in all policy and procedures, and measuring and building psychosocial safety climate, ensuring effective communication and collaboration with employees, and management commitment.</td>
</tr>
<tr>
<td>PRIMARY</td>
<td><strong>PREVENTION</strong></td>
<td>Making changes to physical aspects of the environment including layout and design of buildings, and the equipment and furniture within. Referred to as ‘Crime prevention through environmental design’ (CPTED), this strategy aims to minimise the likelihood and costs of violence.</td>
</tr>
<tr>
<td></td>
<td>Public awareness</td>
<td>Environment &amp; equipment design</td>
</tr>
<tr>
<td></td>
<td>Org. Culture &amp; Climate</td>
<td>Job and task design</td>
</tr>
<tr>
<td></td>
<td>Staff training and education</td>
<td>Altering job designs and staffing patterns to reduce situations where staff at higher risk of violence.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Strengthening the capacity of individual staff members to prevent/respond to violence in an educational program covering training in post-incident action, response, prevention, and theory.</td>
</tr>
<tr>
<td>SECONDARY</td>
<td><strong>PROTECTION</strong></td>
<td>Planning and educating staff on response strategies for when violence occurs or is imminent to help manage incidents safely and protect people involved.</td>
</tr>
<tr>
<td></td>
<td>Emergency situation response</td>
<td>Implementing effective response strategies</td>
</tr>
<tr>
<td>TERTIARY</td>
<td><strong>TREATMENT</strong></td>
<td>Implementing an effective and well used incident reporting system to provide a means of assessing risk and effectiveness of management strategies, and learning form events.</td>
</tr>
<tr>
<td></td>
<td>Incident reporting</td>
<td>Support for victims</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-incident follow-ups, debriefing and evaluation to support victims and help them to cope after they have been involved in an incident.</td>
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policy further specifies ways in which the safety and security of the physical environment can be improved, including “minimising public access points” and “implementing systems for staff to screen patients”. Of particular relevance to remote area nurses is the recommendation from the Australian Nursing Federation that employers “develop and implement policies and procedures for nurses and midwives working in isolation or external to the facility” in relation to violence and aggression in the workplace. Despite such policies and recommendations, however, the incidents of workplace violence do appear to be increasing.

There is an increasing need to actively implement these policies in administration and practice. The robust implementation of such policies will require the participation and collaboration of all stakeholders, including remote area nurses themselves, state and federal governments, unions, occupational health and safety representatives, and other professional bodies, such as CRANAplus. All stakeholders must present a firm and united front that sends a clear and indisputable message of zero tolerance of workplace violence.

In response to the alleged rape of the remote area nurse in the Torres Strait, an investigation was undertaken by the Queensland Health Ethical Standards Unit and a report was released that detailed the findings and relevant recommendations (Queensland Health, 2008, p. 3). Specifically, one recommendation advised that “a further full audit of Outer Island Health Centres and accommodation units be undertaken by organisation independent of Queensland Health to assess the progress of rectifying workplace health and safety deficiencies”.

Further to this, there is also capacity to establish zero tolerance assessment teams (Clements, DeRanieri, Clark, Manno, & Kuhn, 2005) to evaluate the needs of the workplace and oversee worksite-specific policies and procedures. Such teams may also support the role of an occupational health nurse who implements compulsory education programs that target the identification and management of violence in the workplace and the re-introduction of risk management as part of the remote health clinic orientation procedure. Additionally, there may be systems for mandatory reporting of violent and aggressive incidents.

Poor management practices, with a lack of support for RANs and a lack of responsiveness have been noted by several authors (Lenthall et al., 2009). The response by management to the incident in the Torres Strait sharply illustrates this. Education of managers and improved management practices such as: ‘careful staff recruitment, effective systems for monitoring and feedback, regular lines of communication, scheduled management visits, periodic ‘times out’ at head office and prompt management response to problems has been suggested’ (Lenthall et al., 2009, p. 211).

Psychosocial safety climate concerns freedom from psychological and social risk or harm. Psychosocial safety climate (PSC) is defined as policies, practices, and procedures for the protection of worker psychological health and safety (Dollard, & Bakker, 2010). Dollard and Bakker argue that low PSC may be the preeminent psychosocial risk factor at work, preceding a range of psychosocial risk factors including aggression and violence. There is some empirical evidence to support this. Law, Dollard, Tuckey, and Dormann (2011) in a sample 30 organizations with 215 participants, found that in organizations where employees reported low PSC, there were higher levels of workplace bullying and harassment, more emotional and physical demands, and less supervisor support and procedural justice. Further low PSC was related to both health impairment and reduced engagement via these work conditions.
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respectively. PSC is emerging as a lead indicator of workplace psychosocial hazards (high demands, low resources), psychological health and employee engagement, is and therefore an efficient target for intervention. As argued by Brooks et al., (2010), in order to reduce psychological and social harm, PSC should be targeted. Increasing PSC would be a useful strategy to prevent aggression and stress, to overcome the culture of acceptance and normalization, and to ensure that policies and practices are in place to assist workers recover if assaulted or distressed (Brooks et al., 2010).

Building PSC is described in detail elsewhere (Dollard & Karasek, 2010) and general principles can be applied to reduce aggression and violence through the enactment of relevant policies, practices and principles: as outlined by Brooks et al., (2010, pp. 348-9):

(1) senior management show support for aggression prevention through involvement and commitment; (2) participation and consultation in occupational health and safety issues related to aggression occurs with employees, unions, and occupational health and safety representatives; (3) the prevention of aggression involves all layers of the organization; (4) contributions to resolving aggression concerns in the organization are listened to; (5) workers are encouraged to report and are prepared to report; (6) there is good communication about risks, health, and safety; (6) action is taken to discipline unacceptable aggressive behavior – but does not publish honest mistakes; (7) the public is fully informed about the high PSC standards in relation to aggressive behavior in the healthcare setting, including their own rights and responsibilities; and (8) comprehensive reporting and monitoring systems are developed to identify and control antecedents.

2. Prevention

Environment & equipment design
Strategies to improve the safety of the physical work environment itself include improved security in the home, workplace and when attending to on-call or out-of-hours duties. Improved security might include security screens, adequate locks, alarm installation, Dallas Delta systems (phone systems) and security screens in nurses’ residences. There has been considerable debate among RANs and managers concerning the use of high fences creating compounds. On the one hand it may improve security, while conversely, some people feel it creates a “them and us” mentality, negatively impacting on the relationship between the nurses and the community and indirectly increasing the risk to the nurses.

Job and task design
Given that working in isolation is consistently identified as a risk factor for violence against nurses (ICN, 2007) the practice of single nurse posts is particularly risky. According to Lenthall et al. (2011), there are currently fifty-nine (n = 59) single nurse primary health care (PHC) clinics in operational existence across the country. The majority of nurses in single nurse PHC clinics are employed by state and territory governments.

CRANA (2003) and the Australian Nursing Federation (ANF) (2004) do not support the employment of remote area nurses in single nurse posts due to increased stressors such as professional isolation, fatigue, safety, quality and exploitation. The relatively low number of Northern Territory Department of Health and Families single nurse clinics (n = 11) reflects the current policy of phasing out these clinics (Office of the Chief Minister, Northern Territory, 2004). Queensland, Western Australia and Aboriginal Community Controlled
Health Organisations (ACCHOs) are yet to establish a similar policy. The evidence is indisputable – single nurse clinics need to be abolished.

In clinics with more than one nurse there are numerous times when the nurse is treating a client on his/her own. RANs are also one of few remaining professions who attend to call-outs at night and on their own. Job and task redesign could reduce the risk of violence against RANs by introducing measures that prevent RANs attending to clients on their own. Measures might include the co-attendance of Indigenous Health Workers or night drivers (if called out after dark) and should consider an overall increase in numbers of Indigenous workers employed by the health clinics. This would result in reduced ‘alone’ time for the RANs and may also function to de-emphasise the “them and us” mentality.

Staff training and education
Many RANs have reported that knowledge of the local community and culture can promote a positive relationship with community members and act as a protective factor against violence. RAN orientation and education should include modules that may assist RANs in developing these positive relationships, such as cross cultural education, cultural safety and Primary Health Care (PHC). Education on aggression management that aims to empower the nurse to control and diffuse an aggressive situation is also essential. This should include de-escalation skills (including communication and self protection strategies) and education relating to the identification of behavioural precursors to violence. Unfortunately, research undertaken in 2010 demonstrated that around 30% of registered nurses in very remote Australia received no formal orientation, and of the 70% who did receive some formal orientation, about 50% considered it to be inadequate (Rickard, Lenthal, Wakeman, Opie, Dunn, MacLeod, Dollard, & Knight, 2010).

3. Protection

Emergency situation response
The incident in the Torres Strait illustrated deficiencies in all areas including emergency response. The report by Queensland Health Ethical Standards Unit (Queensland Health, 2008, p. 4), advocated that

the Torres Strait and Northern Peninsula Health Service District (TSNPHSD) should, as a matter of urgency, develop and implement standard operation procedures (SOPS) detailing roles and responsibilities of staff members when responding to critical incidents involving the safety, security and welfare of staff within the district.

Strategies and policies should be developed to manage incidents and minimise the potential physiological and physical effects.

The Bush Support Services (BSS) is a CRANAPlus service specifically designed to support health practitioners in remote areas. Staff within this service provide a 24-hour telephone counselling service and participate in on-going projects to improve the well-being of nurses and other remote healthcare providers. The BSS has also developed a decision-making flow sheet for managers dealing with a critical incident.
4. Treatment

There is a requirement to report incidents of violence in many areas but there is a level of cynicism among RANs surrounding the response from management. Clear reporting guidelines need to be established, including guidelines that specifically relate to timely responses by management.

Support for victims is often difficult in remote areas as the usual reaction after a serious incident is to leave the position. Bush Support Services encourage RANs who have terminated their employment due to a critical incident to continue accessing their service.

RESEARCH AGENDA

The National Health and Medical Research Council (NHMRC) (2002) has developed a resource manual for remote and rural practitioners to assist them in preparing for and responding to violence in ways that will reduce its impact. However, according to the NHMRC (2002) the extent of the problem is yet to be fully documented, with a general lack of evidence on the incidence and prevalence of violence, and the associated risk factors in remote Australia.

As is likely the case in other countries there is currently a lack of national surveillance data that could be aggregated to provide more comprehensive information on these factors (Benveniste, Hibbert, & Runciman, 2005). Calls have therefore been made for a national monitoring system, to share and compare incidents, monitor trends and facilitate learning and response at all levels.

To understand and prevent violence against RANs further research is needed to identify and prioritise hazards. Questions that need answers include what aspects of remote area nursing practice carry a risk of violence? And which hazards present the highest risk of violence in the remote health care context? Research may include examining the environment, the nurse, the client and the organisation. Importantly the measures that could be implemented to decrease the risk of occupational violence towards RANs need to be investigated further.

Further research is required that deconstructs beliefs held by various stakeholders (sometimes even nurses themselves) regarding the professional call to care for those in need and the acceptance of personal risk to physical and psychological injury (Brooks et al., 2010). Research is required to establish whether workers with less experience are at additional risk of violence (Brooks et al, 2010) and to identify appropriate support mechanisms.

CONCLUSION

Workplace violence poses significant threat to the physical and psychological well-being of remote area nurses and to the sustainability of the remote health care workforce. Whilst a number of strategies across all levels have been identified in the response to and management of this issue, future research is essential to determine which of these strategies are most effective. Violence against RANs is occurring at unacceptable levels and is ‘a
fundamental violation of their human rights’ (Fisher et al., 1996, p. 198). This workforce should be empowered and protected.

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REFERENCES


Handbook of Stress in the Professions


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