RMIT UNIVERSITY

Worrying about being hit at work

Report of the ANMF's 10 Point Plan in private aged care facilities across the State of Victoria

Report prepared for:

The Australian Nursing and Midwifery Federation (Victorian Branch) (ANMF)

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Table of contents

"Does a broken ankle, three broken ribs and a black eye count for anything?"

(Milagros, PCA)

1. Executive summary

Research was carried out independently by academics from RMIT University and Deakin University on behalf of the Australian Nursing Midwifery Federation (Victorian Branch) (ANMF) in 2020. The purpose of the study was to examine incidents of workplace violence and how they pose significant challenges for nurses and personal care assistants (PCAs) in private aged care facilities. A review of the literature demonstrated there is a dearth of research on examining the efficacy of workplace practices and interventions, such as the *10 Point Plan* to end violence and aggression, to better manage and mitigate the effects of workplace violence on the well-being of private aged care staff.

This study employs a mixed methods approach through qualitative and quantitative methods including semi-structured interviews and online surveys. There was a total of 60 participants in the qualitative study, comprising 10 managers, 20 registered nurses (RN), 9 enrolled nurses (EN), 6 endorsed enrolled nurses (EEN), and 15 personal care assistants (PCAs).

Based on the qualitative data regarding the *10 Point Plan*, workplace violence, HRM practices and in-role performance outcomes, the research study found:

1. There is an overall lack of knowledge of the *10 Point Plan* and subsequently poor implementation of the *10 Point Plan*.
2. Managers are focused on financial outcomes and meeting minimum standards for accreditation, rather than implementing the *10 Point Plan* or similar strategies to better manage and mitigate violence in private aged care facilities.
3. Management seem to lack the knowledge, training and skills needed to systematically implement the *10 Point Plan*.
4. HRM departments are not 'present' or 'on the ground' in private aged care facilities and HRM is predominantly focused on administrative functions such as 'complying with accreditation standards', 'regulations' 'entitlements' and 'disciplinary hearings'.
5. There are deficiencies in how managers combine their skills, knowledge, and work experience to effectively manage and support nurses and PCAs.
6. A lack of training and development for nurses and PCAs across private aged care facilities.
7. A failure of managers to provide developmental performance and meaningful feedback to nurses and PCAs.
8. Staffing ratios are problematic, because staff cannot always provide the level of care required for residents. Poor nurse-resident ratios seem to be contributing to the incidence of violence at the workplace.
9. Poor nurse-resident ratios seem to be contributing to increasing pressure on nurses and PCAs and their poor mental health outcomes.
10. A lack of training and development for managers, nurses and PCAs around emotional intelligence, resilience and managing emotions.
11. There is a management culture of blame about why workplace violence happens and often nurses/PCAs are held responsible.
12. All staff have experienced increasing incidents of workplace violence in private aged care facilities.

There was a total of eight hundred and twenty-six ANMF members in private aged care who completed the online survey.

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"Violence happens every shift."

(Julia, EN)

Based on the quantitative data, the research study found that:

1. The *10 Point Plan* and HRM practices mitigated the relationship between workplace violence on nurses' and PCAs' and mental health. Higher ratings on the *10 Point Plan* were associated with lower levels of workplace violence and better mental health.
2. Mental health problems were positively associated with burnout, which was positively associated with intention to leave, and interestingly high quality of resident care. This is an important finding because it suggests that nurses irrespective of feeling burnout still provide high quality of resident care. However, they are more likely to want to leave their job to cope with mental health problems and burnout.
3. The majority of respondents had experienced workplace violence at least twice, but more often than not, four or more times.
4. The results indicated that there is a general lack of knowledge among nurses and PCAs of the *10 Point Plan*.

Recommendations are made as follow:

The *10 Point Plan*

1. We recommend private aged care providers implement the *10 Point Plan* and related HRM practices to prevent occupational violence and aggression.

Implementing management training

2. The research findings draw particular attention to the importance of implementing greater training and development for private aged care facility managers.
3. Private aged care facilities need to implement an innovative approach to provide management training around soft management skills, supportive and emotional leadership skills, effective communication and HRM that is more than simply a focus on compliance with regulation and accreditation standards.

Implementing an integrative approach to stop workplace violence

4. An integrative approach to stop workplace violence needs to have a developmental focus, involving various levels of management, including top managers, general managers, deputy managers, directors of nursing, coordinators and supervisors to enhance their commitment and engagement.

Development of HRM structure

5. Private aged care leadership needs to develop appropriate HRM structures and promote effective communications between managers and HRM departments to mitigate workplace violence and manage its effects.

Implementation of HRM practices

6. The role of HRM practices need to be promoted in each private aged care facility in order to implement practices that mitigate the effects of violence against nurses and PCAs.
7. Managers need to consider building the well-being of staff through adopting extensive two-way communication, as well as participative and supportive management practices because these help strengthen nurses' and PCAs' self-confidence and promote positive employment relationships.
8. Managers need to provide opportunities for control, skills use and variety at work because these practices lead to high levels of autonomy which enhance supportive interpersonal relationships and positively influence staff well-being.

2. Introduction and scope

Workplace violence poses a significant challenge for employees in aged care facilities. A review of the literature demonstrates that there is very limited research on examining the efficacy of workplace practices and interventions, such as the *10 Point Plan* to end violence and aggression, to better manage and mitigate the effects of workplace violence on the well-being of aged care staff.

The *10 Point Plan* has been designed as a guide for health care providers, managers and workers to reduce and manage workplace violence and aggression. Research was carried out independently by academics from RMIT University and Deakin University on behalf of the Australian Nursing Midwifery Federation (Victorian Branch) (ANMF). This study was funded by the ANMF.

The report is presented as follows: section 2 outlines the purpose, aim and research questions; section 3 provides literature informing the study; section 4 describes the methodological approach; section 5 briefly introduces the participants of the study; section 6 presents the qualitative findings; section 7 discusses the synthesis of qualitative findings, and finally, section 8 presents recommendations.

"The 10 Point Plan is a tool to guide and investigate incidents of violence and aggression against healthcare employees and help prevent further incidents in the workplace."

3. Purpose, aim and research questions

The purpose of the research study and this report is to inform the ANMF of the findings from qualitative and quantitative data on the *10 Point Plan*, and the implementation of preventative controls in relation to violence and aggression in aged care. We focus on the use of the *10 Point Plan* but also include an examination of broader management practices such as human resource management (HRM) that may support the reduction of occupational aggression and violence.

The *10 Point Plan* sets out the foundations of a system of work intended to prevent occupational violence and aggression and to meet occupational health and safety obligations in relation to the prevention of occupational aggression and violence. The research aims to examine workplace violence in private aged care facilities through the implementation of the *10 Point Plan* and develop recommendations to manage and mitigate the effects of workplace violence against ANMF members working in private aged care facilities.

The main research questions relative to the *10 Point Plan*, workplace violence and in-role performance outcomes are as follows:

3.1 How does the *10 Point Plan* reduce and mitigate the effects of workplace violence on nurses' and PCAs' (personal care assistants) mental health? How does the use of human resource management support the reduction and mitigation of the effects of workplace violence against ANMF members working in aged care facilities?

3.2 How do incidents of workplace violence impact on nurses'/PCAs' mental health?

3.3 How do nurses' and PCAs' mental health issues impact on burnout and subsequently affect in-role performance outcomes such as quality of resident care and intention to leave?

3.4 In what ways do HRM practices such as the *10 point plan* mitigate the effects of workplace violence on nurses' and PCAs' mental health?

3.5 In what ways do mental health issues impact the relationship between workplace violence and nurse/PCA burnout?

3.6 In what ways does burnout impact the relationship between mental health and quality of resident care?

3.7 In what ways does burnout impact the relationship between mental health and intention to leave of nurses/PCAs?

4. A critical analysis of the literature pertaining to workplace violence, aged care sector and the *10 Point Plan*

4.1 Workplace violence against nurses and PCAs

In the extant healthcare literature, violence and aggression presents a critical challenge across healthcare services and aged care facilities internationally (Phillips, 2016; Pich et al., 2017; Ramacciati et al., 2017). Violence represents the highest recorded reason for aged care nurses to submit formal complaints across Australian healthcare services (Chapman et al., 2009).

Nurses and PCAs working in aged care facilities are under substantial long-term demand pressures and appear to be at high risk of workplace violence (Eley et al., 2007; Hegney et al., 2006; Rodwell & Demir, 2014). Workplace violence incidents toward nurses working in aged care facilities may occur because of the conditions of residents and nurses that involve direct and frequent contact with care recipients (Åström et al., 2002; Schmidt et al., 2012). Demanding workloads and low levels of autonomy are potential factors increasing nurses' exposure to workplace violence in aged care facilities (Australian College of Nursing, 2018; Hills et al., 2018; Rodwell & Martin, 2013). It has been reported that each year in Australia 65% of aged care nurses experience workplace violence compared to occupational therapists and physiotherapists who account for 42% and 27%, respectively (Mullan & Badger, 2007).

The consequences of workplace violence may have impact on aged care nurses' and PCAs' well-being relative to other nurses because of the increase in the frequency of violence especially in dementia care (Rodwell & Martin, 2013; Rodwell et al., 2009; Schmidt et al., 2012). More than 50% of residents in aged care facilities are living with a dementia diagnosis (Dornin, 2019). Workplace violence negatively influences long-term psychological and physical health (Safe Work Australia, 2017) and leads to significant short-term effects in work performance (Hassankhani et al., 2017; Lanctôt & Guay, 2014).

4.2 The aged care sector in Australia and violence against nurses/PCAs

The aged care sector contributes significantly to the Australian economy, employing nurses, personal care assistants (PCAs), support staff and allied health professionals (Deloitte Access Economics, 2016). The estimated aged care workforce comprises over 366,000 employees (Australian Government Department of Health, 2018). Of these, 235,764 are employed in residential aged care facilities and 130,263 in home and community care (HACC) and home care (Australian Department of Health, 2017).

The aged care sector faces difficulties in attracting and retaining skilled employees leading to current and a predicted future aged care workforce shortages (Montague et al., 2015). Factors contributing to difficulty retaining employees include poor work environments, lack of workplace health and safety, inadequate (non-mandated) client-staff ratios, pay rates and a lack of skills development, career paths, and professional development opportunities (Australian Department of Health, 2017b). In Australia, over 70 percent of 366,000 aged care workers have experienced some form of workplace violence leading to high levels of job turnover (New South Wales Nurses and Midwives Association, 2016). Working in aged care facilities is recognised as being physically and emotionally demanding (McNeil et al., 2019; Pariona Cabrera et al., 2020), which can lead to risks to employee health and well-being (Bartram et al., 2012).

4.3 The *10 Point Plan*

The *10 Point Plan* is a recent response to the number of incidents of violence in the workplace. The Australian Nursing and Midwifery Federation (Victorian Branch) (ANMF) disseminated the *10 Point Plan* to all public acute health services including hospital facilities and emergency departments (Australian Nursing and Midwifery Federation, 2017). The *10 Point Plan* is a tool to guide and investigate incidents of violence and aggression against healthcare employees and help prevent further incidents in the workplace (Australian Nursing and Midwifery Federation, 2014). It is a way to describe controls that are required to be implemented and enables a gap analysis of systems in used at the workplace.

The *10 Point Plan* includes 10 measures; preventing violence through workplace design, providing education and training to healthcare staff, including family in the development of patient care plans, reporting/investigating/acting, integrating legislation, policies and procedures, providing post-incident support, applying anti-violence approach across all health disciplines, and empowering staff to expect a safe workplace (Australian Nursing and Midwifery Federation, 2014). The implementation of the *10 Point Plan* is meant to ensure health service facilities provide a safe work environment for all employees (Australian Nursing and Midwifery Federation, 2017). To ensure the future care of increasing numbers of residents in private aged care, more needs to be done to protect and ensure the continued work of nurses and PCAs.

5. Methodological approach to the study

5.1 Mixed methods approach

This study employs a mixed methods approach through qualitative and quantitative methods including semi-structured interviews and online surveys. The integration of approaches such as qualitative and quantitative studies provide a comprehensive understanding of the research problem and research questions through data collection and data analysis (Kemper et al., 2003). By using both approaches, biases inherent in any single method can be neutralised or biases of other methods can be cancelled (Johnson & Onwuegbuzie, 2004). The mixed-methods approach also maximises the strengths of each approach and minimises the weakness of each method individually (Creswell & Plano Clark, 2017; Teddlie & Yu, 2007). For instance, the use of a qualitative approach, such as semi-structured interviews, contributes to enhancing the depth of the understandings by presenting various stakeholder perspectives but in some cases conclusions cannot be generalised if the number of participants are low (Denzin, 2008). The use of a quantitative approach, such as online surveys, contributes to a broad representation of findings but does not capture the human experience in depth (Creswell, 2013). Therefore, the adoption of the mixed-methods approach by combining both provides an extended understanding of the research problem and research questions (Greene, 2008). The following sections present the qualitative and quantitative studies.

"Family members get quite angry and aggressive about the care their loved ones receive. But they should talk rather than yell."

(Revoreda, PCA)

6. Qualitative study

There was a total of 60 participants in the qualitative study. The recordings of interviews and handwritten interview notes were transcribed and analysed using NVivo (Lewis & Silver, 2007), following the steps of content analysis outlined by Weber (1990). The transcription of all interviews was coded independently by two coders until saturation. All data were de-identified and two coders were used to ensure the reliability of the coding framework. Where there was disagreement between the coders, a third rater was employed to finalise the coding.

6.1 Ethical considerations

This study was approved by the RMIT Human Research Ethics Committee (HREC). The researchers submitted the HREC application form with all relevant documentation, such as the consent form, participant information statement, a protocol for interviews, recruitment message, and interview questions. The RMIT University HREC evaluated if this study met the requirements of the National Statement on Ethical Conduct in Human Research (NSECHR). After a positive evaluation, the HREC granted formal approval via formal letter. After that approval, data collection commenced.

6.2 Participant recruitment

The ANMF liaised with prospective participants and a recruitment message via a fortnightly email newsletter was sent to ANMF members working in aged care facilities (nurses and PCAs). The newsletter outlined the aims and benefits of the research project and interested participants were invited to contact the researcher via email. Importantly, each participant was assured that this was a confidential and voluntary exercise (Schensul, 1999). Participant Information Statements and Consent Forms were then provided to each participant and signed consent obtained prior to the commencement of data collection.

6.3 Participants of the qualitative study

There was a total of 60 participants in the qualitative study, comprising 10 managers, 20 registered nurses (RN), 9 enrolled nurses (EN), 6 endorsed enrolled nurses (EEN), and 15 personal care assistants (PCAs). Within this study, participants made up of registered nurses (RN), enrolled endorsed nurses (EEN), enrolled nurses (EN) are referred to as 'nurses' and PCAs. Each of the participants came from private aged care facilities. We did not find any two participants from the same aged care facility. We applied pseudonyms to each of the participants. The terms 'mental health' and 'well-being' are used interchangeably because participants used both terms during interviews to describe the impact on their health.

6.4 Qualitative findings

The data are presented according to a classification of the healthcare professionals: 20 RNs, six EENs, nine ENs and 15 PCAs. As explained above, these are referred to collectively as nurses and PCAs, and RNs, EENs and ENs as nurses.

6.4.1 Managers and nurse and PCA views on the *10 Point Plan*

There is a lack of knowledge of the purpose of the 10 Point Plan. Throughout the interviews, managers made it clear that whilst some of them are aware of the 10 Point Plan, they had reservations that it may not work in practice. The perceptions of participants were not based on any analysis of the *10 Point Plan* and in many cases, participants had no knowledge of it being implemented in-part or in-full. There seems to be a lack of knowledge of and understanding of the purpose of the *10 Point Plan*. There was little understanding from interview participants that the *10 Point Plan* was a systematic preventative tool. Also, nurses and PCAs reported that they know very little and most said they do not know anything about the *10 Point Plan*. This is not surprising, given that there has not been a concerted campaign to distribute nor inform the private aged care sector about the 10 point plan, but it has been widely distributed and publicised in other parts of the health sector. Based on their experiences of occupational violence and aggression, some doubted that the *10 Point Plan* would minimise incidences of violence in aged care facilities. However, it is to be noted that the Plan may have reduced incidents of violence and aggression, but they have not been recognised or acknowledged by the participants in our qualitative study.

To examine the impact of the *10 Point Plan* on the reduction of occupational violence and aggression we have surveyed nurse and PCA members of the ANMF (Victoria Branch). This is illustrated by the following narratives:

The 10 Point Plan is fine on paper but in practice has little impact. It's my job to ensure the nursing staff are safe... when an incident happens we certainly don't go and look at the 10 Point Plan to find out how to manage it. We don't say... hang on a minute, stop punching, hitting, spitting... while we look up the 10 Point Plan to see how to handle this. It's just not realistic... the government didn't bother to ask our input... they just tell us how to manage violence and incidents from a text book perspective.
(Nancy, Manager)

No, I don't know anything about the 10 Point Plan. I haven't encountered it yet. I was never told about the 10 Point Plan.
(Luisa, RN)

The 10 Point Plan is not going to change a lot... it's just reporting... it's just a tick the box... but it doesn't offer any solution to decrease violence.
(Luana, EEN)

What 10 Point Plan? I don't know what you're talking about. We don't have any such thing... we don't have much at the place where I work.
(Ana, PCA)

6.4.2 Managers' views on the role of the HR department

Managers reported the role of the HRM department was mainly focused on administration, such as employment contracts, hiring and the enterprise bargaining agreement (EBA), as described by the following participants:

HR assists me with the hiring process, employment contracts, and EBA. They give general suggestions.
(Lidia, M)

HR steps in to investigate when there is a conflict between staff and residents. The HR department advises if an employee should be dismissed.
(Rosaura, M)

HR helps me in hiring casual staff, managing any issues, conflict resolution and disciplinary actions.
(Fanny, M)

HR is basically ineffectual. They don't do much other than legislative stuff.
(Yasna, M)

Interesting question? HR doesn't help really. HR has no idea what it's like in a facility. If ever an incident was reported to HR, they would say, 'Are they really injured?'
(Nancy, M)

6.4.3 Nurses' and PCAs' views on the role of the HR department

Nurses and PCAs revealed a lack of HR support and issues around their work. This was evidenced by nurses and PCA participants when they expressed their disappointment about the role of the HR department. It was the overall view of participants that HR is responsible for the prevention of violence and aggression in the workplace. This is concerning given that occupational health and safety is legislated and yet (based on the experiences of some participations) not focussed on by HR Departments. Most participants advised that HR was generally focused on legislation/ regulation and the responsibilities of aged care facilities, such as meeting accreditation standards, regulations and disciplinary hearings, rather than focussing on systematic approaches for the reduction and management of occupational violence and aggression.

A lack of their participation was revealed through their narratives:

HR offers just regulatory previsions about regulation and accreditation standards. They just fulfil the statutory obligations basically.
(Roberto, EEN)

The only time we have heard about HR is when there's a disciplinary hearing. There's no support from HR and it's difficult to contact them. The only way is by email – but they never answer our enquiries.
(Fabiola, RN)

The HR department only looks after the contractual stuff. HR doesn't necessarily support you on the ground.
(Gerardo, EEN)

HR does simple things like a payroll query. We have to write up a query and leave it to admin. We don't deal with them [HR] directly. They don't get back to us. HR should manage the staff differently.
(Monica, PCA)

To be honest, I actually don't know what the HR people do in aged care facilities. I think they deal with rostering and payroll.
(Daniela, EN)

Nurses and PCAs also reported communication issues between the HR department and staff and highlighted areas for improvement. Participants suggested the need for the HR department to find different ways such as education and internal communication to stay in contact with the staff to support nurses and PCAs:

Normally we don't have any interactions with HR. They should support the staff and they should find ways to get in touch with the staff regularly.
(Seferina, EN)

I think HR presence can improve. We don't know much about HR. We should have more education about the HR role. They should send an email every month about what they do or make a presentation on the intranet.
(Erika, EN)

I think HR does administrative stuff, but they're invisible.
(Alicia, EEN)

6.4.4 Managers views on workplace violence in aged care facilities

Managers described incidents of violence against nurses and PCAs. When the researchers asked about workplace violence, managers offered concurrent responses on how staff experienced verbal and physical violence on a daily basis. This was revealed through the narratives:

Residents are very violent with nurses and PCAs. They threaten the staff every day: they punch and shout at staff; in some cases, we've got to go into lockdown and isolate residents who are causing the problem.
(Yasna, M)

His [resident's] outburst was unexplained. He'd been lashing out physically, hurled a pot plant at the wall. He was calling the staff 'f...ing useless animals'. He grabbed me by my right arm and twisted it so hard I had instant bruising. I thought it was broken [and] it's still tender to touch. This happens frequently and we have no option but to deal with each case as it happens.
(Rita, M)

We've violent residents all the time. Staff have to deal with many incidents of violence every day. Residents are physically and verbally aggressive with staff. Residents are hitting, pushing, scratching, swearing, and yelling.
(Lidia, M)

Managers described how nurses and PCAs also experienced incidents of violence from family members and visitors. Managers, Rosaura and Fanny explained:

Relatives say horrendous things to the staff. I always try to support my staff as much as I can, but dealing with people is very hard. As a manager, you're in the middle and you've got to deal with staff, residents, and relatives.
(Rosaura, M)

Violence against the staff is always here. Residents are violent, but also family members and visitors: they constantly yell and humiliate the staff.
(Fanny, M)

Managers also reported how violence occurred between residents and how this has led to difficult situations affecting other residents, as well as staff members. Managers commented:

One resident told another to 'shut up and stop lying', so he picked up a bowl of soup and tipped it over the resident. That started a panic situation. Other residents in the dining and recreation room were screaming, and within minutes residents were throwing anything they could get their hands on to stop him from attacking them.
(Yasna, M)

There was a resident-to-resident incident, in the same room, husband and wife: the husband raped the wife. It was a really difficult one to handle. It was a genuine rape and the best way to manage was to get the police involved.
(Nancy, M)

6.4.5 Nurse and PCA views on workplace violence in aged care facilities

Nurses and PCAs explained incidents of violence and their frequent experience of physical and verbal violence from residents. A lack of management support was unanimously expressed by participants. Staff described their negative experiences:

A male resident was on the floor. We tried to sit him up and he hit us [two staff]. He doesn't know what he's doing, because he's got dementia. He hit us in

the face, body, arms. We put him in a hoist and after 5 or 10 minutes he gets back on the floor. We got no management support.
(Luisa, RN)

Five weeks ago, a violent man, he stomped down the door. He then walked down the hallway with just an incontinence pad on: just try and picture that sight. He pushed himself into me and I fell on the floor. We're spat at, kicked, abused, told we're terrible at our job.
(Marta, PCA)

I was recently assaulted by an elderly lady with dementia. She punched me repeatedly in the face. She was gripping me, punching, and pinching. We have behaviour plans, but these incidents happen when you don't expect it. She smacked me in the face. I've had multiple incidents. It's [the violence] increasing.
(Alicia, EEN)

Does a broken ankle, three broken ribs and a black eye count for anything? Well, there you go, there's my experience. Every day we've got incidents of verbal and physical violence at work. Managers should support us, but they don't.
(Milagros, PCA)

So, two things are in my mind about violence in my facility: verbal and physical violence. This is happening every day and residents are very violent. They can say terrible things against the staff. Managers do nothing to solve this chronic issue.
(Emma, EN)

Participants also mentioned that workplace violence was perpetrated by relatives and visitors. Nurses and PCAs reported verbal violence and they suggested the need for managers to listen and support the staff. This is illustrated throughout the following narratives:

You can get abusive residents but also abusive relatives and visitors. They [relatives and visitors] say unbelievable things against the staff. Managers only listen to the relatives' side, they never listen to and support staff. It's terrible.
(Roberto, EEN)

Family members get quite angry and aggressive about the care their loved ones receive. But they should talk rather than yell. This interferes with our job. It'd be great to have my manager support me when this occurs.
(Revoreda, PCA)

Violence happens every shift. Residents and families are violent against staff. Residents hit, bite and scratch. Relatives and visitors don't want to listen to explanations and they just come to yell and point fingers at you. They say the nastiest things to you. (Julia, EN)

Residents and relatives are violent. I've been smacked in my head and chest. I've been kicked. I've been spat on. Family members are verbally aggressive. I'm sick of violence at my facility. Managers should support us. (Nicol, RN)

Nurses and PCAs also reported violence between residents. Most participants described how verbal and physical violence between residents frequently happened in the dementia unit; resident-to-resident violence occurred unexpectedly and affected residents and staff members:

I've seen residents throwing things at other residents. There's a lot of verbal aggression in aged care. Some days it's a little bit harder than others.
(Renata, EN)

We've had quite a few incidents of violence between residents. These incidents include physical and verbal violence, and this constantly happens in the dementia unit. It comes from nowhere and it affects residents and staff. It's difficult to handle.
(Carmen, PCA)

We've a lot of incidents of violence between residents, especially in the dementia wing. It happens regularly: they scream for everything and throw things. It's terrible and it's unexpected.
(Vania, RN)

People with dementia often lash out for no clear reason. They're violent with other residents. They hurl insults, scream, push and hit other residents without any reason. It creates a lot of problems with residents and their families.
(Gerardo, EEN)

6.4.6 Managers' views on consequences of workplace violence

Managers talked about how workplace violence impacted on their mental health and that incidents of violence generated negative feelings such as stress, irritability, and helplessness which led to burnout manifestations. This was evidenced when managers voiced their frustration in dealing with residents, relatives and staff. Participants also reported they often requested a holiday or sick leave to manage these negative emotions, as stated by the managers:

Violence impacts a lot – physically, emotionally and mentally. I'm always stressed, it's happening every day, I feel helpless. After incidents of violence, I have to deal with people and it's not only with residents but also with families and staff. This is challenging. Aged care needs a huge overhaul.
(Alejandra, M)

Workplace violence stresses everyone: managers, staff and residents. I've had to ask the HR department and unions what to do. It's a stressful environment. I'm stressed and anxious. This happens every single day. I'm drained and fatigued because of this chronic situation. Sometimes I take a day off.
(Fanny, M)

Incidents of violence have a major impact on me because I have to deal with residents, relatives and staff. This takes a chunk of my time. It causes stress, it's an ongoing issue, I'm exhausted. It's very difficult to manage because relatives complain about staff and then I've got to find solutions. But staff think I'm against them. This is frustrating. I usually ask for sick leave.
(Lidia, M)

The researchers also explored management views on the consequences of workplace violence on staff mental health. Managers explained that nurses and PCAs were affected by incidents of violence and all the participants reported feeling stressed, anxious and upset and emotionally drained. This is illustrated throughout the following narratives:

It's very hard: the impact on the staff is high. The PCAs, especially them, because they're doing the work with the residents.
(Nancy, M)

When there's an incident, it's difficult to get staff to keep working. We're usually short- staffed, we can't let them go home or for counselling. It's not ideal but we have to push on, and, yes, at the expense of how the staff are coping.
(Yasna, M)

I've had staff who have left work in tears. Staff are close to residents. They're doing heavy duties. Staff are so frazzled.
(Alejandra, M)

It [workplace violence] affects everyone negatively. Staff are stressed and anxious, exhausted, they're not able to do their job and definitely staff performance decreases a lot.
(Rosaura, M)

After staff face physical or verbal violence from residents, they're stressed and after they're emotionally drained. It takes all their energy to do a proper job.
(Fanny, M)

6.4.7 Nurses' and PCAs' views on consequences of workplace violence

In this section, nurses and PCAs revealed the consequences of workplace violence on their mental health. Staff explained that after they experienced workplace violence, they felt stressed and burnt out. Participants were largely unanimous in their views on how management support was needed to improve employee wellbeing across aged care facilities, and this was emphasised in all conversations with nurses and PCAs:

Workplace violence affects my mental health. I'm stressed, irritable, and nervous. You accumulate these negative emotions and then you're burnt out. I can't sleep very well. Management support in the aged care sector would be ideal but this is almost impossible.
(Emma, EN)

My mental health is very bad and I'm currently on one month's stress leave. I'm stressed, scared and upset. You can't ignore your feelings. I'm burnt out and the doctor gave me another month today.
(Ana, PCA)

Workplace violence is terrible for all of us. It's destroying the aged care industry. We're stressed and exhausted. This should stop and we don't deserve this treatment. It affects your well-being.
(Josefina, EEN)

Workplace violence impacts 100 % of my mental health because it's difficult to deal with physical and verbal violence. It's like a daily occurrence. I'm stressed and exhausted. If managers had ears for listening to us everything could be different.
(Karen, RN)

It was apparent that workplace violence impacted on nurses' and PCAs' well-being. Most participants described they felt anxious, helpless and tearful. Nurses and PCAs consistently mentioned how difficult it was to control the negative emotions leading to emotional exhaustion, diminished satisfaction and job disengagement. Staff offered the following explanations:

Workplace violence has a terrible impact on my mental health. I definitely feel very anxious. It impacts on my emotions and my feelings and sometimes I'm unable to cope with it. All my body systems react.
(Seferina, EN)

I feel extremely anxious, tearful and vulnerable. Any slight noise was likely to startle me. Even if it [workplace violence] happened 18 months ago and I still have these negative feelings about what happened back then.
(Gloria, RN)

Violence at work should stop. I'm nervous and afraid and I'm constantly thinking what could happen again. This [violence] is out of my control. I've lost my motivation to come to work.
(Luana, EEN)

It's not only physical but mentally very draining for us [staff]. It affects us a lot because you become scared and alert in the situation. You feel anxious, very tired and cry sometimes here. These days I feel I don't want to come to work.
(Carmen, PCA)

When the researcher asked nurses and PCAs about the impact of workplace violence on their mental health, participants reported they experienced depression, and repeated

negative feelings and thoughts leading to burnout including a lack of confidence and lack of motivation. These feelings of depression, negative thoughts leading to burnout, lack of confidence and lack of motivation are highlighted in the following narratives:

I feel every day is a bad day. I'm depressed, fatigued and exhausted, because this [workplace violence] is happening all the time. I take sick days because it's difficult to cope with it.
(Fabiola, RN)

I feel down, my confidence is on the floor. I think whatever you do is not good enough. This discourages me a lot. Many days I don't want to come back to work.
(Julia, EN)

Violence causes negative feelings. I'm struggling to believe I'm able to do any job. Negative thoughts come to my mind all the time. I feel very demotivated and exhausted. Managers don't recognise the trauma that you've gone through.
(Arturo, EEN)

It makes me want to call up sick the next day because I can't manage. I feel helpless and hopeless. This [violence] is happening frequently. I shrivel up inside. I have flashbacks. It's been dreadful. I feel very exhausted. I don't sleep well.
(Veronica, PCA)

6.4.8 Facilities as businesses

Nurses and PCAs reported issues around minimum standards for accreditation. When the researchers enquired about challenges at work, participants expressed funding and cutting expenses as the only important factors for managers. Most participants suggested that managers needed to support staff because this impacted on their own well-being and quality of resident care:

Managers seem to care more about the monetary side of things: they just see the dollars coming through the door – another resident, so more money for them – which is sad. It shouldn't be like that.
(Revoreda, PCA)

Everything here is run like a factory and it's all about money. The manager just wants to get accreditation without supporting employees. This impacts on our confidence, because managers use staff for their own benefit.
(Roberto EEN)

My facility is trying to keep the residents there for financial reasons. Managers promise too much to residents and their relatives. We can't meet the promises. Managers care about money. They don't care about staff.
(Renata, EN)

If you need equipment and you go to management, they say, 'There's not enough money'. But they'll build a new facility that costs $30 million. We can't have a $200 piece of equipment... They're just very money hungry and greedy.
(Nicol, RN)

6.4.9 Management attitudes

There are issues in relation to management support across aged care facilities. There are deficiencies in how managers combine their skills, knowledge, and work experience to effectively manage and support nurses and PCAs and implement the 10 Point Plan or the principles contained therein. Most staff expressed their disappointment concerning management communication, rewards, and validation, particularly after they have experienced incidents of violence, as stated by the following participants:

Senior managers should be trained about emotional intelligence... managers should be competent in that area... how to manage employees because they should treat us as human beings and not as simple resources.
(Fabiola, RN)

It's important to have a balance of management knowledge, work experience and how to manage people, work as a team and listen to the staff... employees should be able to express their ideas without fear.
(Renata, EN)

Managers should reinforce our work in simple ways... employee of the month.
(Leonor, RN)

... validation of how you feel... it's very important for us to cope with difficult days.
(Erika, EN)

When people get in a managerial role, they do not have previous experience in any nursing role or personal care role... they are in a business role... they have a business target to meet.
(Alicia, EEN)

Managers should talk to the staff on a daily basis... why did that not work? what do you think we could do better?
(Seferina, EN)

6.4.10 Culture of blame

The study found that management tends to blame nurses and PCAs when there are incidents of violence and aggression involving residents, as described by the following participants:

Managers always turn the blame onto the staff...there's tactlessness in what they say... instead of managers saying, "What did you do (to the resident)?" they should say, "What happened?" "How can we do better?"
(EN, Julia)

It's not about blaming the staff...managers should focus on how this incident of violence will never happen again... whatever factor is... that culture of blaming should stop.
(EEN, Josefina)

There needs to be a "no-blame culture"... let's look at what are the issues... how can we support you to have a better outcome in the work environment.
(Nicole, RN)

6.4.11 Nurse and PCA views on collective ANMF representation

Nurses and PCAs highlighted the role of collective representation as a job resource and how this protected the staff against physical or verbal violence and provided an adequate level of security. This was evidenced by participants when they expressed their satisfaction with the presence of ANMF representatives and OHS officers. Most participants reported that their voice was heard, and protection was present, leading to positive feelings:

We had quite a lot of violence and aggression and it wasn't until we banded together... [and] the union was involved, and it was very important because our voice was heard. I felt protected and it helped to have other reactions about dealing with violence at work and we really showed that managers need to do something about it.
(Marco, EN)

I've had to get the union involved on several occasions to basically force managers to give us support and this helped me a lot.
(Nicol, RN)

After I had an awful experience with a violent resident, the union helped me a lot. I feel someone protected my rights. This impacts on my emotions and my work.
(Amanda, EEN)

My complaint was only heard when the OHS officer from the union came and tried to find a solution. Otherwise, until today, my manager will say, 'It's your fault'. This [union involvement] helps me to feel better.
(Gino, PCA)

6.4.12 Managers' views on staffing practices

Managers reported issues with staffing practices across aged care facilities. This was evidenced when participants expressed their disappointment with staff-resident ratios and how an imbalance of staff to residents impacted on staff mental health and quality of resident care. Managers explained:

We don't have the ratio of staff to work effectively with residents. This affects nurses' and PCAs' feelings: they feel under a lot of pressure, they can't work properly.
(Nancy, M)

There's not enough staff here. This definitely causes many problems in the facility. It's a problem for everyone – for the nurses, PCAs, residents, relatives and visitors. My staff feel overwhelmed.
(Alejandra, M)

We're working more with less staff. This is a huge issue. You can't imagine how difficult it is: staff are frustrated and the quality [of work] wouldn't be that good, because they're running out of time. It's an unsafe work environment for all of us.
(Fanny, M)

There's always been a problem of not enough staff on the floor. Nurses and PCAs are tired of this. It's a chronic issue – they can't work properly.
(Lidia, M)

6.4.13 Nurse and PCA views on staffing practices

Nurses and PCAs explained employment issues that related to staff ratios and the need for more nurses and PCAs relative to the number of residents. As a job resource, participants expressed how the imbalance of staff to residents and the pressure of work impacted on their mental health and quality of resident care. Nurse/PCA participants felt that they worked under pressure, which in some cases lead to perceptions of comprised quality of care. They suggested implementing regulations through governments and the Royal Commission into Aged Care to increase staff ratios across aged care facilities, as stated by the following participants:

It's a high care unit and I have to rely on people to come and help me. You're always rushing, and you never get to slow down or stop. This is no good for our well-being and we can't give proper care to residents. We're understaffed and this needs to improve.
(Mayra, PCA)

Staff ratio is a huge issue in aged care. We need regulations to back us up. The Royal Commission should do something. This is a very urgent issue to solve. It affects staff and residents. We feel overwhelmed and quality of care is poor.
(Milder, RN)

We are constantly short-staffed and we feel stressed and overwhelmed. This should change. We need regulation to take this more seriously. The government needs to do something, otherwise nothing will happen.
(Seferina, EN)

Staff ratios need to be increased to protect residents' and employees' well-being. Minimum staffing ratios in aged care facilities should improve... I don't have 500 legs.
(Luana, EEN)

We are so chronically short-staffed. Since I started working in aged care, nothing has changed. I hope the government implements regulations to support us. This destroys our self-confidence and our work. (Daniela, EN).

Participants also described staffing issues related to managers' preference for employing PCAs instead of RNs. Nurses expressed their concern because managers had opted to hire more PCAs rather than RNs; this reduced labour costs at the expense of nurses' well-being and quality of resident care. This is illustrated throughout the following narratives:

We can't ignore what's happening in aged care facilities. We're struggling to get staff. We're doing more with less staff. Managers are just concerned about cost-cutting. Managers hire more PCAs than RNs. This reduces their expenses. They don't care about employees' well-being... they care about making a profit.
(Elizabeth, RN)

There's not enough staff there to help out with and support in general. We have many PCAs, but they're not well trained. Then this overloads nurses. This is the biggest problem and affects everyone: staff, residents, relatives, industry.
(Arturo, EEN)

Everybody overworks. They don't have time for caring for residents properly. Managers are using the wrong people to do the job – more PCAs compared to RN. PCAs aren't qualified to do it and it's a quite broad issue across the aged care industry. This is wrong.
(Humberto, EN)

6.6.14 Managers' views on possible factors impacting the quality of resident care

Managers commented on the possible factors that negatively impacted on the quality of care. They explained that, when nurses and PCAs experienced incidents of violence, they reported feeling overwhelmed, stressed and exhausted, which affected their quality of resident care. The following statements highlight the issues around quality of care:

Workplace violence impacts everyone. It's happening every single day. Staff are overwhelmed, stressed, and very exhausted. They lose their motivation to give proper care to residents.
(Lidia M)

After staff experience incidents of violence, they're stressed and emotionally drained. They can't concentrate and do a proper job [i.e., to care for residents].
(Fanny, M)

Violence impacts how staff care for residents. Sometimes it's just a needle to keep them quiet. If we had more staff, we could spend more time on their care.
(Rita, M)

6.6.15 Nurses' and PCAs' views on possible factors impacting the quality of resident care

From nurse and PCA perspectives, it was evident that the quality of resident care was negatively impacted by factors such as workplace violence, lack of control, stress, irritability, and exhaustion.

Combined, these factors influenced how nurses and PCAs carried out their work and the overall quality of resident care was revealed through the narratives:

It [violence] impacts heaps. If I'm stressed and exhausted, I would take a longer time to get things done. It's so much work – what will happen with the next resident? I can make mistakes. It's hard to control.
(Luana, EEN)

After incidents of violence, I become more cautious about what I have to do. It's a heavy burden. I feel stressed and irritable. It takes all my energy and I'm very exhausted: this definitely impacts on caring for the residents.
(Luisa, RN)

If you don't feel safe in your workplace because of violence, you're going to do as little work as you can. You would get out of here [work] as quickly as possible. The quality of your work [with residents] is affected.
(Veronica, PCA)

When you are stressed and drained, you will not give 100%. You just want to quickly finish your job and go home. You doubt about your ability to do your job properly and it does affect enormously your quality of resident care.
(Julia, EN)

6.6.16 Managers' views on reasons impacting intention to leave

Managers described the main reasons they might leave their current employment. Factors included stress, frustration, and burnout manifestations. Participants highlighted how important it was to prioritise their mental and physical health over their roles, as Yasna and Nancy explained:

I left my job because I had enough. I came to the realisation that nothing was going to change, so I had to make the change. It became an easy decision in the end, because it was the job versus my mental and physical health.
(Yasna, M)

I did do something and left a few months ago, because of stress and burnout, and I don't see something good in the aged care sector.
(Nancy, M)

Managers also indicated their intention to leave their job because of stress, fatigue and lack of hierarchical support:

I'm in the process of getting out of the aged care [sector]. I just can't do it anymore. I'm physically... and mentally... very tired. The director of nursing doesn't listen. You just fight a losing battle every single day.
(Alejandra, M)

In fact, I said to myself, I will leave this job because of stress, fatigue and exhaustion. I have had enough, I can't handle the job. Top managers never support us.
(Fanny, M)

Yes, I thought to leave this job. It's because of more and more frustration, and how things are run. I'm sure nothing will change in this industry [aged care]. The State Manager is absent.
(Rosaura, M)

6.6.17 Nurses' and PCAs' views on reasons for intention to leave

Nurses and PCAs explained that stress, frustration and emotional exhaustion were the main reasons for considering leaving the job. Staff offered the following explanations:

I've thought of leaving my job because I'm frustrated, stressed and exhausted. Unfortunately nothing is done to solve this ongoing issue [violence]. It'd be nice to go to work without having to worry that you're going to be hit. This is not fair.
(Seferina, EN)

Yes, I'm looking around for other jobs. I want to change my profession. I know this will make me move to another town, but it doesn't matter. I can't handle stress, exhaustion and fatigue. My self-satisfaction is under the floor. Negative attitudes from the manager towards staff are terrible.
(Hugo, RN)

Yes, I'm going to leave my job because it's unpleasant. I feel stressed and emotionally drained. I can't cope with it anymore. You can't imagine, this is dreadful. Management always blames staff for everything.
(Pamela, PCA)

"It'd be great to have my manager support me..."

(Revoreda, PCA)

"Workplace violence stresses everyone: managers, staff and residents. I've had to ask the HR department and unions what to do."

(Fanny, M)

7. Synthesis of qualitative findings

7.1 Based on the data regarding the *10 Point Plan*, workplace violence, HRM practices and in-role performance outcomes, interviews with 10 managers and 50 nurses and PCAs the research study found:

7.2 There is an overall lack of knowledge of the *10 Point Plan* and subsequently poor implementation of the *10 Point Plan*. There was no acknowledgement by interview participants that even any of the principles or components of the *10 Point Plan* had been implemented in the aged care facilities.

7.3 Managers are focused on financial outcomes and meeting minimum standards for accreditation, rather than implementing the *10 Point Plan* or similar strategies to better manage and mitigate violence in private aged care facilities.

7.4 Management seem to lack the knowledge, training and skills needed to systematically implement the *10 Point Plan*.

7.5 HRM departments are not 'present' or 'on the ground' in private aged care facilities and HRM is predominantly focused on administrative functions such as 'complying with accreditation standards', 'regulations' 'entitlements' and 'disciplinary hearings'.

7.6 There are deficiencies in how managers combine their skills, knowledge, and work experience to effectively manage and support nurses and PCAs. Most staff expressed their disappointment concerning management communication, meaningful rewards, validation, flexible work arrangements, particularly after they have experienced incidents of violence.

7.7 A lack of training and development for nurses and PCAs across private aged care facilities. Nurses and PCAs voiced their concerns that they were unable to attend training and development sessions due to understaffing.

7.8 A failure of managers to provide developmental performance and meaningful feedback to nurses and PCAs. Most participants expressed the need to be valued and appreciated by managers.

7.9 Staffing ratios are problematic, because staff cannot always provide the level of care required for residents. Poor nurse-resident ratios seem to be contributing to the incidence of violence at the workplace.

7.10 Poor nurse-resident ratios seem to be contributing to increasing pressure on nurses and PCAs and their poor mental health outcomes.

7.11 A lack of training and development for managers, nurses and PCAs around emotional intelligence, resilience and managing emotions.

7.12 There is a management culture of blame about why workplace violence happens and often nurses/PCAs are held responsible.

7.13 All staff have experienced increasing incidents of workplace violence in private aged care facilities.

7.14 Incidents of workplace violence from the perspectives of participants has the potential to negatively impact the quality of resident care and increase intention to leave among nurses and PCAs.

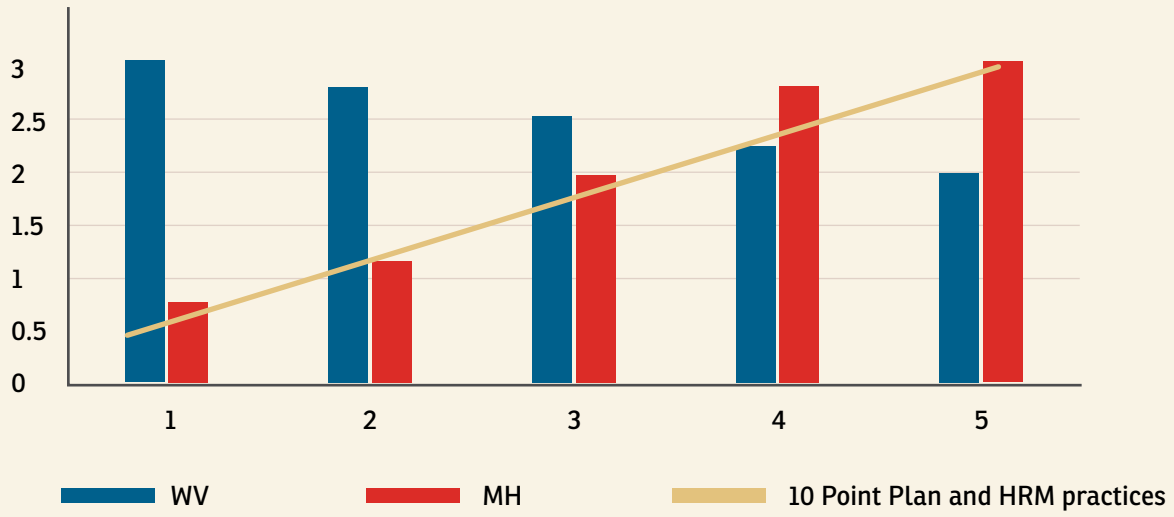

Figure 1: The role of 10 Point Plan and HRM practices

8. Quantitative study

This section of the final report presents the quantitative results of the online survey. This research study employed an online survey to collect data from members of the ANMF employed in private aged care facilities (inclusive of all non-government owned aged care providers). The online survey was distributed to the staff in February 2020 (Wave 1) and in June 2020 (Wave 2).

"I'm drained and fatigued because of this chronic situation."

(Fanny, M)

8.1 Recruitment of participants

Recruitment emails were sent via newsletters to the members of the Australian Nursing Midwifery Federation (ANMF) employed in private aged care facilities across the State of Victoria. Directors of nursing, managers, registered nurses, enrolled nurses and personal care assistants were invited to participate in the online survey. These emails also stated that they would find attached the Information Participant Statement, which provided details about the study. Submission of the survey was considered as implied consent to participate. Respondents were informed that participation was voluntary, anonymous and confidential.

8.2 Participants of the quantitative study

We sent questionnaires out to approximately 8,000 ANMF members working in private aged care. Eight hundred and twenty-six ANMF members in aged care completed the online survey. Of 826 respondents, 365 and 224 completed Wave 1 and Wave 2 respectively.

8.3 Online survey instruments

The online survey included questions about the *10 Point Plan to End Violence and Aggression*, HRM practices along with other instruments including workplace violence, mental health, burnout, quality of resident care and intention to leave. It also included respondents' demographic information. The online surveys were preceded by clear information explaining the purpose of the online survey and participation was voluntary and confidential.

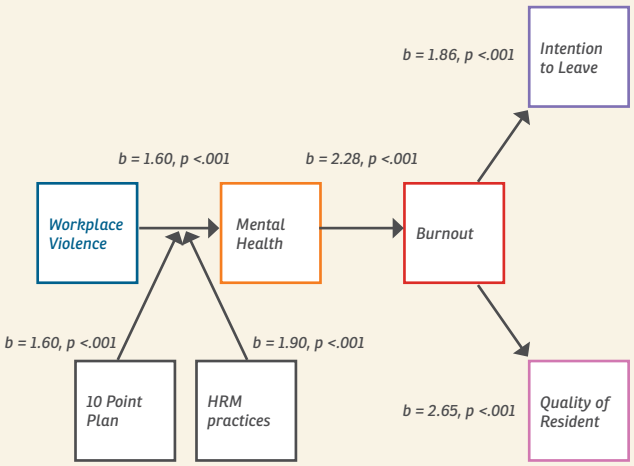

Figure 2: Wave 1 results

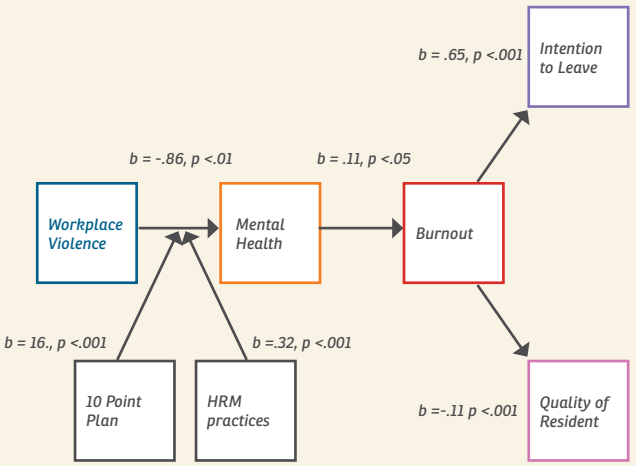

Figure 3: Wave 2 results

8.4 Data collection

Data were collected February 2020 and June 2020. Respondents completed the Online Surveys through Qualtrics Web Link. The online surveys were deidentified and respondents had an anonymous code that consisted of the first two letters of their first name, then the middle two digits from their date of birth and two letters that began the name of the suburb where they lived. Finally, respondents were given the option to provide their email address if they wished to participate in the second wave.

8.5 Quantitative results

In this section, we present the results of the Wave 2 survey and contrast them against the results of the Wave 1 survey to create a complete picture of respondents' views in relation to several key variables. These key variables include workplace violence, the 10 Point Plan, HRM practices, burnout, mental health, intention to leave and quality of resident care. Data were analysed using a combination of robust data analytic techniques such as sequential mediated regression and moderated hierarchical regression. Post-hoc tests were also conducted to ensure results obtained were reliable and valid.

8.5.1 The role of the *10 Point Plan* and HRM practices

In Wave 2, we examined the role of the 10 Point Plan and HRM practices as moderators of the relationship between workplace violence and mental health. We further investigated the sequential roles of mental health and burnout on the relationship between workplace violence and the intention to leave, as well as the quality of resident care.

Similar to the findings reported for Wave 1, we found that the *10 Point Plan* and HRM practices mitigated the relationship between workplace violence on nurses' and PCAs' and mental health. Higher ratings on the *10 Point Plan* are associated with lower levels of workplace violence and better mental health. The results are displayed in *Figure 1.*

8.5.2 The role of the *10 Point Plan* and other variables

The combined role of the *10 Point Plan* and HRM practices contributes to the management and mitigation of the effects of workplace violence on nurses and PCAs' mental health, burnout, and subsequent performance outcomes such as intention to leave and quality of resident care.

We present this model in *Figure 2*, which illustrates our findings from Wave 1.

As *Figure 2* illustrates, the coefficients between the variables were statistically significant. The results indicate that the presence of the *10 Point Plan* and HRM practices such as participative management, formalised occupational health and safety practices and training and development reduce the negative effects of workplace violence on the mental health (i.e., anxiety, depression and stress) of nurses and PCAs.

We also found evidence that mental health problems were positively associated with burnout, which was positively associated with intention to leave, and interestingly high quality of resident care. This is an important finding because it suggests that nurses irrespective of feeling burnout still provide high quality of resident care. However, they are more likely to want to leave their job to cope with mental health problems and burnout. We also found a significant negative correlation between the *10 Point Plan* and HRM, and the experience of workplace violence. When HRM and the *10 Point Plan* are both implemented this has a stronger effect on reducing workplace violence.

Following the interesting findings from Wave 1, we re-tested the model after collecting the Wave 2 data (which was collected during the COVID-19 pandemic). *Figure 3* illustrates our findings.

The coefficients of each of the variables were all statistically significant. Both the *10 Point Plan* and HRM practices continue to have a mitigating effect on workplace violence's impact on the mental health of nurses and PCAs. Mental health problems were positively associated with burnout, which was positively related to intention to leave. Burnout was negatively related to the quality of resident care, which is both a theory-consistent and practically consistent effect we originally expected to see in Wave 1. This is a direct contrast to the previous findings in Wave 1 (see *Figure 2*), where burnout was positively associated with quality of resident care. In Wave 1, this was an important finding, as it suggested that nurses irrespective of feeling burnout still provide high quality of resident care. The findings in Wave 2 suggest that as nurses and PCAs increasingly feel burnout and its effects (during COVID-19), the quality of resident care may be negatively impacted. This is an important finding especially during a time of unprecedented crisis in the aged care sector as a result of the COVID-19 pandemic.

8.5.3 Incidences of workplace violence

Table 1 presents the percentages of incidences of workplace violence that nurses and PCAs experience and suffer on a day-to-day basis in both Wave 1 and Wave 2.

TYPE OF VIOLENCE	WAVE 1	WAVE 2	PERCENTAGE CHANGE FROM WAVE 1 TO WAVE 2
Hit, kicked, grabbed, shoved or pushed by anyone while at work	93.3%	86.2%	-7.1%
Spat on or bitten	73.3%	69.1%	-4.2%
Object thrown at nurse/PCA	72.7%	70.1%	-2.6%
Threatened with physical violence	86.7%	84.8%	-1.9%
Threatened with a weapon	43.6%	32.1%	-11.5%
Personal or workplace property damaged	38.2%	40.6%	+2.4%
Threatened to damage any personal or workplace property	33.3%	35.7%	+2.4%
Door slammed in face	55.8%	52.7%	-3.1%
Yelled or shouted at	95.8%	95.5%	-0.3%
Sworn at	94.5%	88.8%	-5.7%
Glared at	93.9%	91.5%	-2.4%
Seen co-worker or manager experience violent events at work	89.7%	88.8%	-0.9%
Heard about co-worker or manager experience violent events at work	94.5%	94.6%	+0.1%
Seen co-workers or managers being threatened with physical violence at work	84.8%	84.8%	No change

Table 1: Incidences of workplace violence experienced by nurses and PCAs (Percentage of respondents)

While there is an overall general downward trend in the acts of violence perpetrated against nurses and PCAs from Wave 1 to Wave 2 in percentage terms, the incidence of violence remain at extremely high levels. The downward trend (in percentage terms) may be a direct result of the severe lockdowns Melbourne has endured during the COVID-19 pandemic. The lockdowns have essentially isolated residents, which has also meant that some staff have not been able to attend work and some residents confined to their rooms.

When we examined the frequencies of the different acts of violence, we found that the majority of respondents had experienced these acts at least twice, but more often than not, four or more times. We found that this increase of frequency of violence from Wave 1 to Wave 2 may be the result of some residents' frustration at social distancing and isolation practices in many Victorian private aged care facilities.

The following tables present the frequencies (raw numbers) of acts of physical violence towards nurses and PCAs.

FREQUENCY	WAVE 1	WAVE 2
Never	11	31
One (1) time	14	17
2-3 times	42	50
4 or more times	98	127

Table 2: Hit, kicked, grabbed, shoved or pushed by anyone at work

Nurses and PCAs were asked, "Have you been hit, kicked, grabbed, shoved or pushed by anyone while you've been at work?. Table 2 shows, there has been an increase of physical violence in frequency terms (four or more times) from 98 (Wave 1) to 127 (Wave 2).

FREQUENCY	WAVE 1	WAVE 2
Never	44	69
One (1) time	23	32
2-3 times	39	59
4 or more times	59	65

Table 3: Spat on or bitten by anyone while at work

As illustrated in Table 3, nurses and PCAs reported they had experienced physical violence. There has been an increase in frequency terms (four or more times) from 59 (Wave 1) to 65 (Wave 2).

FREQUENCY	WAVE 1	WAVE 2
Never	45	67
One (1) time	26	50
2-3 times	42	53
4 or more times	52	55

Table 4: Had an object thrown at you while at work

As Table 4 shows, there has been an increase from wave 1 to wave 2 in frequency terms. Nurses and PCAs reported that they had experienced physical violence at least twice from 42 (Wave 1) to 53 (Wave 2).

FREQUENCY	WAVE 1	WAVE 2
Never	22	34
One (1) time	9	20
2-3 times	37	69
4 or more times	97	102

Table 5: Threatened with any of the above examples of physical violence while at work

The majority of respondents reported they had been threatened while they had been at work. As Table 5 illustrates, there has been an increase in frequency terms (four or more times) from 97 (Wave 1) to 102 (Wave 2).

FREQUENCY	WAVE 1	WAVE 2
Never	93	152
One (1) time	28	36
2-3 times	27	19
4 or more times	17	18

Table 6: Threatened with a weapon while at work

As Table 6 illustrates, incidents where nurses and PCAs have been threatened with a weapon while at work. There has been an increase from 28 (Wave 1) to 36 (Wave 2). Violence with a weapon may have escalated due to residents being in isolation and their confusion and increased frustrations.

FREQUENCY	WAVE 1	WAVE 2
Never	102	133
One (1) time	23	40
2-3 times	20	30
4 or more times	20	22

Table 7: Personal or work property been damaged by someone at work

Nurses and PCAs were asked, "Has your personal property or workplace property been damaged by someone at work?" Table 7 shows, there has been an increase in frequency terms (four or more times) from 20 (Wave 1) to 22 (Wave 2).

FREQUENCY	WAVE 1	WAVE 2
Never	110	144
One (1) time	14	31
2-3 times	20	40
4 or more times	21	10

Table 8: Someone threatened to damage your personal or workplace property while at work

As Table 8 shows, nurses and PCAs reported that they had experienced threatening behaviors at work concerning to damage their personal or workplace property.

There has been an increase in frequency terms (two to three times) from 20 (Wave 1) to 40 (Wave 2).

FREQUENCY	WAVE 1	WAVE 2
Never	73	106
One (1) time	28	34
2-3 times	35	59
4 or more times	29	26

Table 9: Had a door slammed in your face while at work

As Table 9 illustrates, nurses and PCAs reported that they had experienced a door slammed in their face while at work. There has been an increase in frequency terms (two-three times) from 35 (Wave 1) to 59 (Wave 2).

The following tables present the frequencies of acts of psychological violence towards nurses and PCAs.

FREQUENCY	WAVE 1	WAVE 2
Never	7	10
One (1) time	10	14
2-3 times	31	52
4 or more times	117	149

Table 10: Been yelled at or shouted at while at work

Nurses and PCAs were asked, "Have you been yelled at or shouted at while you've been at work?" Table 10 shows, they had experienced psychological violence. There has been an increase in frequency terms (four or more times) from 98 (Wave 1) to 127 (Wave 2).

FREQUENCY	WAVE 1	WAVE 2
Never	9	25
One (1) time	10	10
2-3 times	32	42
4 or more times	114	148

Table 11: Been sworn at while at work

As illustrated in Table 11, nurses and PCAs reported they had experienced psychological violence ("Have you been sworn at while you've been at work?'). There has been an increase in frequency terms (four or more times) from114 (Wave 1) to 148 (Wave 2).

FREQUENCY	WAVE 1	WAVE 2
Never	10	19
One (1) time	6	10
2-3 times	29	45
4 or more times	120	151

Table 12: Been glared at while at work

Nurses and PCAs reported that they had experienced psychological violence ("Have you been glared at while you've been at work?"). Table 12 illustrates that there has been an increase in frequency terms (four or more times) from 120 (Wave 1) to 151 (Wave 2).

The following tables present the frequencies of acts of vicarious violence experienced by nurses and PCAs. Vicarious violence refers to the experience of witnessing or hearing violent events or threatening actions directed toward coworkers or supervisors in the workplace.

FREQUENCY	WAVE 1	WAVE 2
Never	17	25
One (1) time	13	22
2-3 times	44	61
4 or more times	91	117

Table 13: Seen a co-worker/manager experiencing violent events at work

Nurses and PCAs were asked, "Have you seen any of your co-workers/managers experiencing violent events at work?" The majority of respondents indicated they had experienced vicarious violence. As Table 13 shows, there has been an increase in frequency terms (four or more times) from 91 (Wave 1) to 117 (Wave 2). The increase in the frequency of violence from Wave 1 to Wave 2 may be exacerbated by the current isolation conditions.

FREQUENCY	WAVE 1	WAVE 2
Never	9	12
One (1) time	8	13
2-3 times	34	58
4 or more times	114	142

Table 14: Heard about any co-worker/managers experiencing violent events at work

Similarly, the majority of respondents reported they had heard about many co-worker/managers experiencing violent events at work. As Table 14 illustrates, there has been an increase in frequency terms (four or more times) from 114 (Wave 1) to 142 (Wave 2).

FREQUENCY	WAVE 1	WAVE 2
Never	25	34
One (1) time	18	17
2-3 times	36	61
4 or more times	86	112

Table 15: Seen any co-workers/managers being threatened with physical violence at work

Finally, nurses and PCAs reported that they had seen many co-workers/managers being threatened with physical violence at work. As Table 15 shows, there has been an increase in frequency terms (four or more times) between 86 (Wave 1) to 112 (Wave 2).

8.5.4 Sexual harassment

Sexual harassment is any form of unwelcome sexual behaviour that is offensive, humiliating, or intimidating. It can be written, verbal or physical (Spector et al., 2014). In both Wave 1 and Wave 2 surveys, we asked respondents the extent to which they had experienced any inappropriate or offensive behaviour (e.g. touching, groping, comments, attempts to hug, or offensive jokes) from residents. Table 16 presents the percentage of respondents who have experienced incidences of sexual harassment at work from both the Wave 1 and Wave 2 surveys.

SEXUAL HARASSMENT	WAVE 1	WAVE 2	PERCENTAGE CHANGE FROM WAVE 1 TO WAVE 2
Experienced any inappropriate or offensive behaviour (e.g. touching, groping, comments, attempts to hug, offensive jokes) from residents	86.7%	87.5%	+0.8%

Table 16: Incidences of sexual harassment at work

In an overwhelming majority, respondents indicated that they had experienced forms of sexual harassment from residents. The incidences of sexual harassment increased slightly from 86.7% of Wave 1 respondents to 87.5% of Wave 2 respondents.

We further investigated the frequencies of these instances of sexual harassment. Table 17 presents the results.

FREQUENCY	WAVE 1	WAVE 2
Never	22	28
One (1) time	16	12
2-3 times	34	59
4 or more times	93	126

Table 17: Experienced any inappropriate or offensive behaviour from residents

There remains a very high frequency of sexual harassment of nurses and PCAs in the workplace. Most respondents indicated they had experienced sexual harassment two or three times whilst at work. Overwhelmingly, there was a high number of respondents who reported they had experienced sexual harassment four or more times at work.

"Workplace violence has a terrible impact on my mental health. I definitely feel very anxious. It impacts on my emotions and my feelings and sometimes I'm unable to cope with it. All my body systems react."

(Seferina, EN)

"Violence causes negative feelings.. Negative thoughts come to my mind all the time. I feel very demotivated and exhausted."

(Arturo, EEN)

8.5.5 The *10 Point Plan*

Mirroring our approach in Wave 1, we asked respondents in the Wave 2 survey about their perceptions and knowledge of the dimensions of the *10 Point Plan*. Table 18 presents the results. Our results indicated that there is a general lack of knowledge among nurses and PCAs of the *10 Point Plan* across both Waves 1 and 2.

10 POINT PLAN	N	MINIMUM	MAXIMUM	MEAN	STD. DEVIATION
Plan Report	365	1	5	3.23	1.14
Plan Empower	365	1	5	2.91	1.1
Plan Security	365	1	5	2.9	1.17
Plan Fam	365	1	5	2.9	1.15
Plan Train	365	1	5	2.8	1.26
Plan Design	365	1	5	2.7	1.05
Plan AntiViolAppr	365	1	5	2.7	1.14
Plan Support	365	1	5	2.55	1.17
Plan Risk	365	1	5	2.54	1.24
Plan Legis	365	1	5	2.41	1.16

Table 18: Respondent knowledge of the 10 Point Plan – Wave 1

Scores from the first wave survey in February ranged from a low of 2.4 to a high of 3.2. These scores indicated that there was limited knowledge of the *10 Point Plan* among nurses and PCAs.

In the second wave survey in June, we re-examined respondents' knowledge of the *10 Point Plan*. Table 19 presents these results.

10 POINT PLAN	N	MINIMUM	MAXIMUM	MEAN	STD. DEVIATION
Plan Report	224	1	5	3.33	1.28
Plan Empower	224	1	5	3.18	0.59
Plan Security	224	1	5	2.40	1.11
Plan Fam	224	1	5	2.84	1.20
Plan Train	224	1	5	2.62	1.21
Plan Design	224	1	5	2.52	1.15
Plan AntiViolAppr	224	1	5	2.87	1.19
Plan Support	224	1	5	2.53	1.28
Plan Risk	224	1	5	2.69	1.21
Plan Legis	224	1	5	2.89	1.16

Table 19: Respondent knowledge of the 10 Point Plan – Wave 2

Scores from the second wave survey ranged from a low of 2.4 to a high of 3.7. The scores from the second wave survey do not appear to be different from the scores from the first wave survey. We conducted a test to see if there was a statistically significant difference in the scores from Wave 1 to Wave 2 (i.e. to determine if there is a meaningful change in the values from the first survey to the second). The test determined that there was no statistically significant change in values from the first wave to the second. This indicates that the values – and the lack of knowledge of the *10 Point Plan* – remained stable across the time between surveys.

8.5.6 The *10 Point Plan* across groups

Our Wave 1 survey compared the responses of nurses to PCAs regarding all of the dimensions of the *10 Point Plan*. Table 20 presents these results.

10 POINT PLAN	ROLE	N	MEAN
All areas	Nurse	181	2.81
	PCA	71	2.5
Plan Security	Nurse	181	2.93
	PCA	71	2.8
Plan Risk	Nurse	181	2.65
	PCA	71	2.24
Plan Fam	Nurse	181	3
	PCA	71	2.58
Plan Report	Nurse	181	3.31
	PCA	71	2.84
Plan Design	Nurse	181	2.68
	PCA	71	2.46
Plan Train	Nurse	181	2.9
	PCA	71	2.43
Plan Legis	Nurse	181	2.42
	PCA	71	2.1
Plan Support	Nurse	181	2.5
	PCA	71	2.37
Plan AntiViolAppr	Nurse	181	2.72
	PCA	71	2.42
Plan Empower	Nurse	181	2.94
	PCA	71	2.71

Table 20: Wave 1 responses broken into roles: Nurses and PCAs

Nurses tended to report higher ratings of knowledge of the different dimensions of the *10 Point Plan* than PCAs, however, this difference was not statistically significant. We also examined the ratings of knowledge of the dimensions of the *10 Point Plan* for nurses and PCAs in the second wave survey. Table 21 presents these results.

10 POINT PLAN	ROLE	N	MEAN
All areas	Nurse	170	2.81
	PCA	54	2.45
Plan Security	Nurse	170	2.42
	PCA	54	2.18
Plan Risk	Nurse	170	2.74
	PCA	54	2.40
Plan Fam	Nurse	170	2.87
	PCA	54	2.53
Plan Report	Nurse	170	3.39
	PCA	54	3.05
Plan Design	Nurse	170	2.50
	PCA	54	2.50
Plan Train	Nurse	170	2.70
	PCA	54	2.31
Plan Legis	Nurse	170	2.90
	PCA	54	2.73
Plan Support	Nurse	170	2.66
	PCA	54	1.97
Plan AntiViolAppr	Nurse	170	2.93
	PCA	54	2.58
Plan Empower	Nurse	170	3.17
	PCA	54	3.17

Table 21: Wave 2 responses broken into roles: Nurses and PCAs

Similar to the findings presented in the preliminary report, we found that nurses reported higher ratings of knowledge of the dimensions of the *10 Point Plan* than PCAs, however, these differences were not statistically significant. We conducted further analyses and also determined that there were no statistically significant differences in the scores reported by nurses or PCAs from Time 1 to Time 2. This indicates a stable baseline of knowledge of the dimensions.

9. Recommendations to improve the management and mitigation of workplace violence against nurses and PCAs

Based on the key findings, a set of recommendations are outlined below:

9.1 The *10 Point Plan*

9.1.1 We recommend private aged care providers implement the *10 Point Plan* and related HRM practices to prevent occupational violence and aggression. This will involve adopting the *10 Point Plan* as a systemic policy across private aged care facilities. Promote the *10 Point Plan* through knowledge sharing and staff meetings of private aged care workers. This may include the development of virtual/online education resources. Promote the commitment of senior managers and middle managers to the implementation of the *10 Point Plan*.

9.1.2 Examine strategies to implement the *10 Point Plan* in private aged care facilities and track (using surveys) progress over time. This may include a campaign outlining the economic benefits for private aged care managers and owners of the importance of reducing workplace violence and its negative effects on nurses and PCAs.

9.2 Implementing management training

The role of management training in private aged care facilities is critical. The research findings draw particular attention to the importance of implementing greater training and development for private aged care facility managers. Private aged care facilities need to invest in and promote the benefits for their managers of participating in training and development regarding HRM and the implementation of the *10 Point Plan*. Private aged care facilities need to implement an innovative approach to provide management training around soft management skills, supportive and emotional leadership skills, effective communication and HRM that is more than simply a focus on compliance with regulation and accreditation standards.

9.3 Evaluation of training

Evaluation of existing violence management training programs needs to be regularly undertaken to assess skill and knowledge retention, effectiveness and sustainability. This can also help determine what worked well and what could be improved in future training programs.

9.4 Implementing an integrative approach to stop workplace violence

An integrative approach to stop workplace violence needs to have a developmental focus, involving various levels of management, including top managers, general managers, deputy managers, directors of nursing, coordinators and supervisors to enhance their commitment and engagement. When all actors in the workplace are involved and supported from the top-down, there will be stronger relationships with staff and better outcomes may be achieved.

9.5 Involving different institutions

Involve organisations to provide training sessions, including government agencies, universities and the ANMF. By delivering management training sessions, private aged care leadership should be able to promote positive employment relationships, build strong connections and increase sensitivity to staff emotional states that ultimately help nurses and PCAs cope with the effects of workplace violence.

9.6 Development of HRM structure

Private aged care leadership needs to develop appropriate HRM structures and promote effective communications between managers and HRM departments. HRM departments in private aged care facilities should be more involved in the role of managers and their strategic function through the use of formalised HRM practices and policies that may enhance nurses' and PCAs' well-being and subsequently drive positive in-role performance such as quality of resident care and intention to leave.

9.7 The role of HRM departments

HRM departments need to take a lead role in providing systematic, formal and informal supports to mitigate the effects of violence on nurses and PCAs. An important starting point for management would be to undertake an audit of current HRM practices in private aged care facilities that are meant to reduce workplace violence and associated negative effects.

9.8 Communication between HRM departments, managers and staff

Managers need to promote better interactions between HRM departments, themselves and staff through different communication channels such as emails, online meetings and internal communication. This may play a significant role in building a positive relationship between HRM departments and staff that may contribute to staff well-being and the staff retention.

9.9 Implementation of HRM practices

9.9.1 The role of HRM practices need to be promoted in each private aged care facility in order to implement practices that mitigate the effects of violence against nurses and PCAs.

9.9.2 Managers need to consider building the well-being of staff through adopting extensive two-way communication, as well as participative and supportive management practices because these help strengthen nurses' and PCAs' self-confidence and promote positive employment relationships.

9.9.3 Managers need to provide opportunities for control, skills use and variety at work because these practices lead to high levels of autonomy which enhance supportive interpersonal relations and positively influence staff well-being.

9.9.4 Managers should focus on staff perception of recognition, acknowledgment, and validation because this increases their self-assurance which affects their mental health.

9.9.5 The results of this study suggest that future implementation of well-being-oriented HRM practices is an appealing prospect for many private aged care facilities, warranting its benefits to nurses' and PCAs' mental health.

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