Workplace aggression in health settings: Prevalence, risks and prevention

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Have you met someone like this?

What is aggression?

1. Action or behaviour by a perpetrator toward a target
2. Perpetrator’s intention to cause harm or damage in order to achieve a proximal or distal outcome
3. Target’s motivation to avoid that action or behaviour
4. Violation of norms the action or behaviour represents (Baron & Richardson, 1994; Krahé, 2001)

• Violence is an extreme form of aggression
What is workplace aggression?

• Any non-physical or physical aggression
  – By a perpetrator toward a target in their workplace

• Potential targets in health settings
  – Clinicians (nursing, medical and allied health)
  – Other care and support personnel

• Potential sources in health settings
  – Patients and their relatives/carers
  – Co-workers
  – Others
How prevalent is it?

• Large national and cross-national studies:
  – Prevalence in health care second only to that for protection and security services personnel
  – Up to 95% reported aggression from patients
  – Up to 50% reported aggression from relatives/carers
  – Up to 40% reported aggression from co-workers
  – Verbal aggression 2-5 times more prevalent than physical forms of aggression
Associated impact & consequences

• Psychological and physical impacts
• Increased absenteeism
• Work restrictions, modifications or transfers
• Decreased job satisfaction
• Decreased organisational commitment
• Increased risks to patient safety and care quality
• Intentions to leave patient care, quit the job or leave the profession
Personal risk factors – perpetrators

- Evidence of elevated risk:
  - Male
  - History of aggression
  - Mental disorder
  - Substance misuse

Personal risk factors – clinicians

- **Gender** – contradictory evidence ... stronger evidence for gender-based / sexual aggression for females
- **Age and work experience** – consistently elevated risk for younger and less experienced clinicians
- **Cultural / linguistic background** – contradictory evidence ... some for discrimination toward international clinicians
- **Clinician personality** – emerging evidence of elevated risk with external control orientation (locus of control)
- **History of previous aggression exposure** – some evidence
Location

- Rural cf. Metropolitan
  - Contradictory evidence
- Lower cf. Higher SES communities, Public cf. Private sector work, Hospital cf. Community-based work
  - Some evidence of elevated risk
- Clinical field or discipline of work
  - Elevated risk where patients/carers experience frustration, distress, or cognitive impairment or arousal

Work arrangements & conditions

- Evidence of elevated risk:
  - Longer working hours
  - Shiftwork, shift switching, mandatory overtime
  - Staff shortages, time pressures
  - Performing physical patient care/tasks
  - Insufficient lighting
  - Home visits and after-hours work

Prevention and minimisation

• High-level advocacy for diverse approaches
  – ILO, ICN, WHO, OSHC (US)

• Research evidence limited, including in health care
  – Expert opinion and theory

• Routine activity theory
  – Focuses on the situational aspects of aggression
Routine activity theory

Perpetrator motivation and opportunity

- Target vulnerability
- Absence of capable guardianship

Workplace aggression in health settings
Hierarchy of controls

• **Elimination (designing out the risk)**
  – Engineering or design considered likely to be more efficacious and cost effective in the longer term

• **Risk minimisation (enclosing or excluding the risk)**
  – Including isolating workers from the hazard (eg behind broad counters or protective screens)

• **Risk reduction (control strategies)**
  – Applying administrative and engineering controls, and education and training
More education and training?

• A typical response in the health sector
  – But inconclusive evidence for safety and efficacy

Source: http://www.theguardian.com/theguardian/2013/oct/11/adult-literacy-night-school
Source: http://youtu.be/uQf7Chx2jBU
Organisational redesign

• Solutions more likely be found in minimising *perpetrator opportunity* and *target vulnerability*, and enabling *capable and credible guardianship*
  
  – Environmental redesign
  – Redeveloping organisational policies and procedures
  – Engaging staff and consumers in meaningful dialogue

Other prevention measures

• Guided by organisational policy:
  – Incident reporting and follow-up systems
  – Patient/public access restrictions
  – Facility security systems
  – Administrative and engineering controls
    • Warning signs
    • Flagging high risk persons
    • Restricting or withdrawing service access to high risk persons
    • Specific after-hours and off-campus safety measures
Legislative reform

• Model legislation introduced from 2011:
  – Workplace aggression not identified as a specific risk

• Implementation and enforcement deficiencies:
  – Some evidence (eg Johnstone et al. 2011) that WH&S personnel are insufficiently trained or equipped to understand and identify psychosocial risks

• Success of legislation targeting WA in health care
  – California and New Jersey (eg Casteel et al. 2009)
Conclusions

• Workplace aggression is a significant risk for clinicians and support personnel

• Organisational responses:
  – Policies and procedures, systems and processes, managerial responsibilities and accountabilities
  – Prevention, risk minimisation and risk reduction

• Policy and legislative reforms:
  – Facilitate & support effective organisational responses

• Ongoing research
Selected references


Thank you

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