

FEAR FOR PERSONAL SAFETY: IMPLICATIONS FOR NURSING EDUCATION

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The Federal Government has accepted that violence is a problem in rural communities across Australia. The 2nd National Rural health Conference recommended that: "rural communities be resourced to develop their own appropriate strategies for health programs such as STD/HIV control, violence and substance abuse".

Anecdotal evidence exists to suggest that the incidence of violence directed towards remote and rural health professionals is increasing. Furthermore, some remote area nurses have reported increasing evidence of violent interaction as a significant motivation for their departure from remote area nursing practice. Limited research has been conducted which specifically addresses the risk and experience of violence to health professionals who practice in remote communities.

The purpose of this study is to validate the anecdotal evidence that violence is a prevalent stressor to health care workers within isolated communities, and to assess their repertoire of coping skills in effectively managing violent situations for the client, community and themselves. The study utilises 'across method triangulation' combining quantitative, in the form of a document review of incident reports and a questionnaire survey of remote area nurses, and qualitative methods in the form of group interviews of selected participants.

This paper will discuss preliminary findings from the questionnaire and the document review phases of the study. Issues such as the severity and frequency of violent incidents, how remote area nurses dealt with violent situations, and their perceptions of their coping skills and need for educational input will be canvassed. The focus of the paper will be on how nursing education at both undergraduate, post graduate and in service levels can better help to prepare nurses confronting violent or potentially violent situations. Health professionals need to know how to respond effectively to the ever present threat to personal safety that can occur in all health care settings.

Introduction

This paper is a progress report of our study aimed at validating anecdotal evidence that suggests violence directed towards remote area nurses (RANs) is increasing, is a prevalent

stressor in remote area nurses practice, and that remote area nurses are ill equipped in managing these violent incidents.

The Federal government has accepted that violence is a problem in rural and remote communities across Australia (National Committee on Violence Against Women 1992). The 2nd National Rural Health Conference recommended that: “rural communities be resourced to develop their own appropriate strategies for health programs such as STD/HIV control, violence and substance abuse” (Malko 1993:249).

Violence against women has been recognised as a serious national problem that Australians can neither afford to condone nor allow to continue” (National Committee on Violence Against Women 1992:1). As remote area nurses and health workers are predominately women, research which clarifies and validates the occurrence and type of violence that is being experienced by remote area nurses is completely relevant to the National Strategy on Violence Against Women. We perceive that violence against remote area nurses is a fundamental violation of their human rights, and should be perceived as a criminal matter which is open to public scrutiny.

This research shares many of the same methodological complexities as that of studying violence against women in the general community. Surveys and research show that violence against women goes mainly unreported and that women may live as silent victims with unresolved guilt, fear and anxiety associated with their experience (National Committee on Violence Against Women 1992). The circumstances that stimulate or provoke violence and provide avenues for the expression of violence are multi-dimensional. Socio-cultural, political, and gender factors are recognised as contributing significantly to violence against rural health workers.

As a step in redressing the lack of data on the experience and description of violence against remote area nurses, the aims of our research are threefold:

To determine the frequency and severity of violent incidents occurring against nurses and health workers employed in remote communities.

To determine whether violence is perceived as a stressor by these remote area nurses and health workers.

To identify whether this population perceive that they have the repertoire of coping skills necessary to effectively manage violent situations.

The research focuses on the collection of data essential in decision making related to the development of appropriate education packages and in service programs for remote area nurses and health workers.

Role of the remote area nurse

RANs have existed in remote parts of Australia for over 100 years. The earliest documentation of the existence of RANs were those employed in Kalgoorlie and Coolgardie in Western Australia in the 1890's (Kreger, 1991). Today, there are 217 remote nursing outposts in pastoral, railway, mining and Aboriginal and Islander communities. The Remote Area Nurse (RAN) has been an integral part of Australia's answer to meet the health care needs of people who are disadvantaged by their geographical isolation.

More consistently than any other professional in Australia, it has been the nurse who has "gone outback" to meet these needs(CRANA, 1993).

A significant aspect of the remote area nurses' role is that these professionals most often practice without the benefit of immediate medical, ancillary and/or other support personnel (Cramer, 1992; 1994). Because of this isolation and lack of other health services, the nature of the RANs work is unique in nursing. Frequently they are expected by their communities to perform duties well beyond the scope of what is normally considered a nursing role. They are often the only health worker in the community and as a result are "informally" on call 24 hours a day 7 days a week. Moreover the working conditions, accommodation and health care resources they can access are frequently substandard (Cramer, 1992; 1994; Kreger, 1991).

Adding to these problems is the fact that usually the RAN's employer organisation is located many hundreds of kilometres away (sometimes this is several days travelling time overland), and at times appear to be, either unaware of, or uninterested in the variety and seriousness of the demands placed upon RAN's (Cramer, 1992).

Living, working and socialising within remote communities can present significant personal and professional challenges, and stress for nurses. (Kreger 1991:5).

Research on violence against nurses

The literature recognises that the type of violence and violent behaviours which occur against health professionals has been greatly under researched (Engel & Marsh, 1986; Ryan & Poster, 1989; Lanza, 1983; Lion, Snyder & Merrill 1981). Prior to 1983 there was little Australian research into violence experienced by nurses. A retrospective study by Lanza (1983) focused on nursing staff assaults over a one year period and found that a significant number of nurses were experiencing violent incidents but were choosing to remain silent. One major study published by the Royal Australian Nurses Federation (Holden, 1985) revealed that out of 310 nurse respondents, 85.8% (266) nurses had been aggressed against by patients and 43% of these had been abused on 1-4 occasions in the last 12 months and 15.8 % of respondents more than 25 times in the same period. These figures represented verbal aggression as well as physical

assault. The issue of personal and sexual safety for RAN's living in remote areas has been mentioned in a number of State and Regional reports (Brown, 1992; CRANA, 1992; Cramer, 1994). However, to the knowledge of this research group, no systematic attempt to gather data on the incidence of violence experienced by RAN's and other remote health workers has occurred.

Compounding this lack of research, both the frequency and severity of violent incidents have been limited by a phenomena of under reporting across all of the relevant literature. A review by Engel and Marsh (1986) cite several other researchers whom have evidenced and statistically validated the significant gap in reported episodes of violence experienced by health professionals including, psychiatrists, psychologists, registered nurses and other hospital employees.

Anecdotal evidence and personal communication from RANs to CRANA, suggests that the incidence of violence directed towards remote area nurses is high and is increasing. One experienced RAN has had her house broken into 21 times over a nine year period, and in one Queensland Regional Health Service two reported rapes of RANs have occurred in the past 3 years, whilst verbal violence and abuse are reportedly daily occurrences (Smith, 1993).

As previously mentioned, a problem with quantifying the incidence of violence is that there tends to be a 'context of silence' over the rate and type of assaults made on RANs. Fear of losing their jobs contributes and perpetuates this context of silence. The literature suggests that when nurses do have the courage to report violent incidents, their employer and colleagues frequently respond by identifying the individual's nursing and interpersonal skills, or lack of these, as somehow having caused or contributed to the problem (Bowie & Malcolm, 1989). These authors suggest that blaming the victim "assists other staff members to distance themselves from the possibility of themselves being violated." Where remote area nurses feel they may be blamed for the violent event, they may understandably become reticent in raising

community awareness to the amount of violence occurring, or in drawing attention to themselves and the state of their job conditions.

In these circumstances resignation may be viewed as a more attractive alternative, again reinforcing the context of silence. Some remote area nurses in Queensland have reported increasing evidence of violent interaction as a significant motivation for their departure from remote area nursing practice (Mc Donald, 1993; Robins 1994). Johnson (1993) reports that remote area nurses staff turnover rate of 200 percent per year is typical for many of these communities.

Contributing to this 'context of silence' is the courage of the RAN's themselves. These nurses go beyond romantic dreams of "going bush" and make an active decision to become a part of that folk law. It takes a particularly adventurous spirit and courage to travel to, and decide to live in an isolated region, let alone to take on the roles and responsibilities of being the only health professional. How this spirit and courage has a potential for adding to the context of silence is encapsulated in an interview reported in Kreger (1991:21).

Jill: Sally actually had a person with a shotgun one night threatening and firing shots.

Sally: Yeah.. ...It's sort of distracting when you are trying to think of your diagnosis.

It appears that as in the issue of domestic violence, and because of the context of silence, the issue of personal safety of RAN's has not been systematically examined, or documented and only rarely discussed in a public forum

Coping skills

Although the last decade of literature has shown an increase in reports related to the frequency of patient assaults toward nurses, there is little in the way of studies which describe nurse's responses to the assault experience, the type of coping skills they employed, or the results of follow up intervention programs that may have given support to the victim.

It is well known that episodes of violence are experienced and interpreted as significant emotional and/or physical traumas for the receiver (Lanza, 1983; Lion, et al 1981; Holden, 1985). Ultimately, these experiences contribute to the physical harm, emotional instability, fear for personal safety, lack of job satisfaction, stress, high staff turnover rates and other chronic or pathological forms of mental and emotional torture for the health worker (Engle & Marsh, 1986).

Holden's (1985) study of assaulted nurses showed that many nurses found it impossible to outwardly express their anger or fear and indirectly found other methods of dealing with these lingering feelings. Many nurses reported feeling "unprofessional" when expressing their feelings associated with violent experiences, and are reluctant to acknowledge their feelings or to even press charges (Lanza, 1984).

A remarkable feature in the literature throughout the 1980's is that the employee or victim was not only blamed in some direct or indirect way by other colleagues, coworkers and hospital administrators for provoking the violent incident (Bowie & Malcolm 1989), but was also denied access to counselling or follow-up debriefing by their employers. For remote area health care professionals this denial may bear a double-edged sword. Firstly, these professionals are geographically inaccessible to backup teams should they require sick leave or special leave for counselling. Similarly, they are often faced with the role conflict of returning to a work environment where they may have to face and/or continue to care for their assailant (Lanza, 1984). The remote area nurse usually lives proximally or

within the same community as their assailant, is geographically isolated, and has no opportunity to shift the responsibility of care for that client to another health worker. Fear and anxiety is increased when one considers the possibility that clients may wish to seek retaliation if reported upon.

The literature has been clear in its emphasis that all professionals and persons who are assaulted require debriefing and post-trauma counselling (Hume 1993; Hoff, 1989 & 1990; Bolger, 1991). In many situations, the incidence of nursing staff experiencing violent incidents in their place of work has prompted the formation of peer support groups in order to facilitate a positive resolution for the victim of the violent or fear provoking incident (Dawson, Johnston, Kehiayan & Kyanko, 1988). However, support must go beyond the immediate or "on the spot" discussion that is provided by colleagues or friends, and entail formal intervention programs such as those provided by victim assault teams, peer support or victim assistance programs (Ryan & Poster, 1989). Janoff-Bulman (1985) suggest that victimisation calls into question our sense of the basic assumptions of the world, and in doing so has the potential to destroy the individual's perception of, and ability to function in, a stable and orderly world; hence, when a violent episode occurs, the world no longer feels safe or orderly. Similarly, it goes without saying that any other client or person who witnessed the violent incidence may require similar debriefing and assurances. Again, these kinds of therapeutic interventions are made extremely difficult by the isolation and remoteness which is experienced by the contingent of rural and remote area nurses and health workers in Australia.

Education Implications

Many reports have focussed on the inadequate preparation for rural and remote practice for all health professionals (Gray & Buckley, 1992; Kreger, 1991; National Rural Health Strategy, 1991; Brown 1992; CRANA, 1992; Cramer, 1994). Hume (1993:90) suggests that "staff should be selected and trained in communication and interpersonal skills...and

made familiar with the premonitory signs of violence.” Improved education and training of RANs is acknowledged in all these reports as being of crucial importance in the preparation for rural and remote area practice and the extended role nurses are required to adopt in these communities. Other educational issues identified include; lack of or inadequate cross-cultural education; lack of or inadequate initial preparation for rural and remote practice; lack of or inadequate continuing education opportunities and lack of professional and personal support to allow RAN’s time off to attend continuing education programs.

Design of the study

Across-method triangulation, combining quantitative and qualitative methods of data collection are utilised in in this study to increase the validity of the findings, ensure a richer data base, give rise to a more complete picture of the phenomenon of violence as it is experienced by this population, and to increase the level of confidence in the capacity of the results to be generalised (Mitchell, 1986).

Figure 1 illustrates the design of the study.

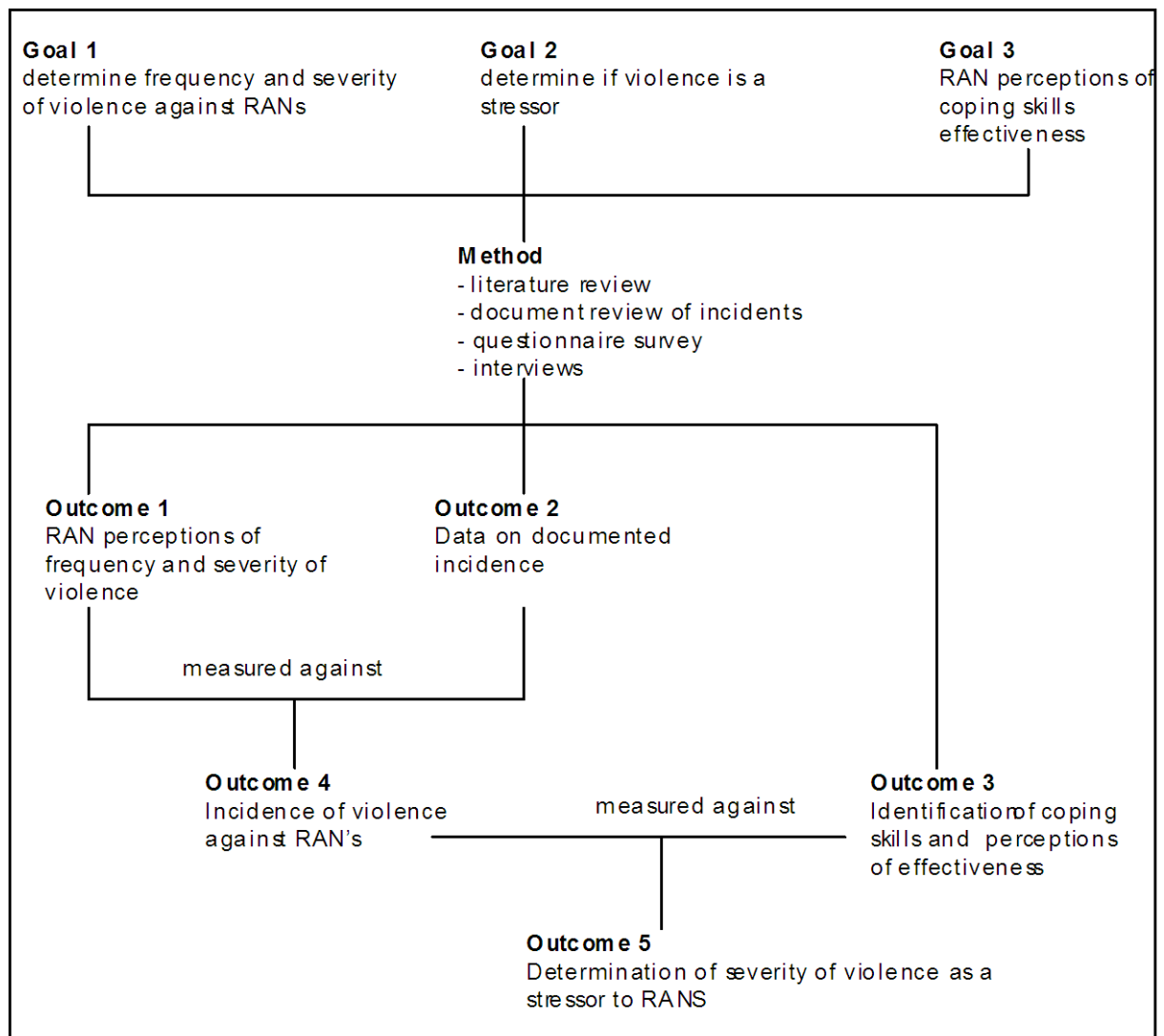


Figure 1

The quantitative research component employs nonexperimental survey studies and document reviews of incident reports. Data was collected from participants using structured questionnaires. Data will also be collected from employing bodies through a document review of reported violence against remote area nurses and health workers.

The qualitative methods included semi structured interviews with ‘volunteer’ RAN’s. The qualitative phase of research will broaden the scope of the quantitative data, and provide invaluable, in depth information on issues surrounding violence as it may occur in this population.

Ethics approval was granted by the Central Queensland University, and consultation with Aboriginal and Torres Strait Islanders at both State, Federal, Community and individual levels has occurred throughout the research process.

Methodology

A questionnaire was administered to all 281 members of the Council of Remote Area Nurses of Australia Incorporated (CRANA). The numbers receiving the questionnaire in each state are listed below.

Queensland	(112)	
New South Wales	(24)	
Northern Territory	(63)	
Victoria	(18)	
South Australia	(23)	
Western Australia	(38)	
Tasmania	(1)	
Australian Capitol Territory	(2)	<u>TOTAL 281</u>

The questionnaire was developed from information gained through a literature review, and discussions with remote area nurses. The questionnaire was divided into 6 parts.

Part A and B assessed demographic background about the respondents and the community in which they worked. The level of professional support they received, and the sense of belongingness they felt towards the community they served.

Part C assessed orientation and in service programs offered and perceptions of the respondents as to their adequacy in preparing them for the reality of their nursing practice.

Part D assessed the frequency and severity of violence experienced by RAN's, as well as perceptions about effectiveness of coping strategies utilised. Violent incidents were divided into 7 types ranging from verbal abuse to rape. Each type of violence assessed was accompanied with a plain English definition of what we meant by that type of violence. For example, "verbal aggression and obscene behaviour" was defined as;

A patient purposefully directs insulting abusive angry or hurtful statements to you, your family, other clients or health workers.

"Stalking" was defined as;

A patient or somebody else purposely stalks or follows you or a client or another health worker to or from home or place of work, with the intention which you feel maybe harmful or threatening.

and Sexual abuse was defined as;

Any forced sexual act, rape or indecent assault that occurs without your full consent.

Part E assessed whether RAN's reported incidents of violence and to whom.

Part F assessed security systems in place and the perceptions of the respondents as to their adequacy.

The full results of the survey are not yet available, however to give an impression of the type of findings arising I have noted some of the descriptions of a violent incident occurring within the past 6 months to respondents to our questionnaire.

I was on call at night, busy dealing with a sick baby in one section of the clinic when a spade was thrown through a whole panel of louvres at the front of the clinic. The perpetrator apparently was angry because his wife has been sent into the regional hospital to await confinement and he was upset about it.

At 3.30 am one night, I was called to attend to someone who was at the local pub and had fallen over hitting their head, receiving a laceration which required suturing. It was also stated by one witness that the person involved looked as though they'd fiddled. The person was 'under the influence' and aggressive - not wanting to get into the hospital vehicle to be checked out and attended to. With the assistance of a friend of the 'victim'. we finally (45 minutes later) persuaded the individual to go to the hospital in the friends car. No verbal abuse was aimed at me directly, however fists were raised at one point. I kept my distance at such times, but I do remember thinking, should I be calling the police. and thankfully I was finally able to examine the person at the hospital and was able to suture their wound.

Called out late one night to a male patient. While treating male patient, female patient arrived having been speared in leg by male defacto. While both patients in clinic, defacto outside - calling out, rattling windows and doors, acting in violent manner, trying to get into building. Defacto returned with rifle - has

history of violence. This went on for about half an hour before State Police called. It took Police approximately 2 hours to arrive from 'town'. In the mean while both patients were treated and kept in clinic till Police arrived for their own protection. Defacto left clinic area after approx 3/4 hour. When State Police arrived he was removed from community. Both patients were then transferred to hospital for further treatment and for their safety.

A nurse came to work one morning and parked her car outside the health centre. Just as she was getting out of the car a very distressed young man shot the back window of her vehicle out with a shotgun at fairly close range. The nurse was uninjured, but suffered critical incident stress and is still unable to work. The previous night the young man who was very dependent on his mother, watched his mother die from myocardial infarction with his 5 other siblings. They were living at an outstation with no communication facilities and no vehicle to bring his mother to the community. The young man was very distressed and so vented his disclosure on what he considered the lack of caring of the nurses.

We have to leave communities prior to sunset or else we can't take off - at least not from this one, which has no lights or flares. Otherwise can't do next days clinics. Had to pack up and go in spite of waiting patients, one of whom became incensed and started throwing rocks at us.Man started throwing rocks at aircraft. Wanted to get one of our passengers.....Assaulted during decent by man who struck me repeatedly because I would not undo seat belt. At least I could get away from him - sort of....Hit by walking stick when would not give patient "medicine". Eventually gave her antibiotics so she would stop yelling. they were an instant cure! Incidents in aircraft are scariest because of inaccessibility of help and vulnerable situation. ie. enclosed space, danger of

accident if patient does any real damage....Don't like to examine incidents too closely. They become too real again.

Conclusion

The purpose of this research is to gather data relating to the frequency and severity of violent incidents experienced by RANs, and to discover to what extent the RANs experiences with violence are stressors in their work. The long term aim of the research is to conduct workshops dealing with this issue. The relevancy of these workshops is dependent upon knowledge about the frequency, severity, and type of violence being experienced, as well as knowledge about commonly used coping skills.

The literature on violence against nurses identifies a context of silence that ensures consistent underreporting by nurses of these events. However, the literature also identifies the experience of violence by nurses in their place of work as being severe, and generally handled badly.

Perhaps of greatest concern is the lack of support from colleagues and employees once a violent incident occurs.

The context of silence that surrounds this issue needs to be overcome so that appropriate policy, post trauma procedures, and preventative education campaigns can be implemented. This is of special concern for RANs who frequently work in isolation, usually know the perpetrator and their family/community well, do not have the opportunity to shift the burden of caring for the individual to another health worker, and do not have access to even informal modes of support.

Violence against RAN's is a fundamental violation of human rights, and like other forms of violence should be perceived as a criminal matter which is open to scrutiny and intervention. Currently "the employer's responsibility for the occupational health and safety of RAN's

appears poorly understood or enforced” (Kreger 1991 p20). This research team believes that acknowledgement of health practitioners as victims of a blame-free traumatic event is of critical importance in the development of policies and intervention programs to address the issue of personal safety of remote area nurses.

References

Brown, L. (1992). *Report on remote area nursing in Queensland 1991*. Peninsular and Torres Strait Regional Health Authority, Queensland Health.

Bolger, A. (1991) *Aboriginal women and violence, A report for the Criminology Research Council and the Northern Territory Commissioner of Police*. Australian National University, North Australia Research Unit, Darwin.

Bowie V.V. & Malcolm, J.P. (1989) Violence Against Human Service Workers, *Advances in Behavioural Medicine*, 6, 160-187.

Cramer, J. (1992). Dilemmas of remote area practice. In Gray, G. & Pratt, R. (Ed). *Issues in Australian Nursing* 3. Melbourne. Churchill Livingstone (pp 133-149).

Council of Remote Area Nurses of Australia Inc. (1993) . Press Release, 13th Feb.

Council of Remote Area Nurses of Australia Inc. (1992). *Occupational health and safety of remote area nurses*. Position Paper Prepared by Queensland Members of CRANA Executive.

Cramer, J. (1994). *Support Needs of Nurses in Remote Areas*. Curtin University of Technology. Perth, W.A.

Dawson, M., Johnston, M., Kehiayan, N., & Kyanko, S. (1988). Response to patient assault. *Journal of Psychosocial Nursing*. 26 (2) 8-12.

Engel, F., & Marsh, S., (1986) Helping the Employee Victim of Violence in Hospitals, *Hospital and Community Psychiatry*, 37,2,159-162.

Gray, G., & Buckley, P., (1992). *Across the spinifex; Registered nurses working in rural and remote South Australia*. Flinders University of S.A.

Hoff, L.A. (1990) *Battered women: private struggles against a public problem*, London: Routledge.

Hoff, L.A. (1989) *People in Crisis*, Redwood: Addison-Wesley.

Holden , R. (1985). Aggression against nurses. *The Australian Nurses Journal*. 15 (3) 44-48.

Hume, F. (1993). The management of the violent and aggressive patient. *Australian Prescriber*. 16 (4) 90-93.

Janoff-Bulman, R. (1988). The aftermath of victimisation: Rebuilding shattered assumptions. In Figley, C.R., (Ed), *Trauma and Its Wake*. New York: Bruner/Mazel.

Johnson, S. (1993). Drunks pose safety risks, nurses claim. *Cairns Post* Feb. 26.

Kreger, A. (1991). *Remote area nursing practise: A question of education*. CRANA Cairns.

Lanza, M.L. (1983) The Reactions of Nursing Staff to Physical Assault by a Patient, *Hospital and Community Psychiatry*, 34,1, 44-47.

Lanza, M.L., (1984) A Follow-up Study of Nurses' Reaction to Physical Assault, *Hospital and Community Psychiatry Service*, 35,5,492-494.

Lion, J.R., Snyder, W., & Merrill, G.L., (1981) Underreporting of Assaults on Staff in a State Hospital, *Hospital & Community Psychiatry Service*, 32,7, 497-498.

Malko, K.N. (Ed) (1993). A fair go for rural health - forward together. *2nd National Rural Health Conference Proceedings*, The University of New England. Armidale.

McDonald, B. (1993). More consultation wanted: Aborigines seek health input. *Cairns Post* April 1. p 13.

Mitchell, E.S. (1986). Multiple triangulation: a methodology for nursing science. *Advances in Nursing Science*, April.

National Committee on Violence Against Women (1992). *The National strategy on violence against women*. Commonwealth of Australia. Canberra.

National Rural Health Strategy (1991). *A Fair Go For Rural Health*. National Rural Health Conference, Toowoomba.

Robins, P. (1994). Lecturer and remote area nurse. Personal Communication.

Ryan, J.A., & Poster, E.C. (1989) The Assaulted Nurse: Short-Term and Long-Term Responses, *Archives of Psychiatric Nursing*, vol III, 6, 323-331.

Smith, J. (1993). *The relationship between remote area nurse retention rates and fear for personal safety*. Unpublished report.

