

**PREVENTING WORKPLACE VIOLENCE:
TOWARD A BEST PRACTICE MODEL
FOR WORK IN THE COMMUNITY**

**Final Report
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**RDNS RESEARCH UNIT
Report prepared by Tina Koch and Sally
Hudson.**

Contact

Professor Tina Koch (RN, PhD)

RDNS Chair in Domiciliary Nursing (A joint position between Royal District Nursing Service and the School of Nursing Flinders University of South Australia)

RDNS (SA) RESEARCH UNIT

31 Flemington Street

Glenside 5065

PO Box 247 Glenside 5065

Telephone (08) 8206 0007

Fax (08) 8206 0010

Email: Tina.Koch@flinders.edu.au

Project Management Team

The Project Management Team consisted of Professor Tina Koch, Pam Wilkinson (ANF), Hennie McAllister (Helping Hand), Michael Kelly (DAIS), Leith Pontifex / Mike Williams RDNS Employee Safety and Rehabilitation (ESR /OH&S) and Sally Hudson (RDNS Research Associate).

Participatory Action Research (PAR) group

The Participatory Action Research group: Nona Dimmock, Graham Dunn, Maddi Crickmar and Di Mills (Northern RDNS Region), Elaine Tooke and Andy Kelly (Central RDNS Region) and Jenny Taylor, Fiona Smith and Jackie Rollins (Southern RDNS Region). Tina Koch and Sally Hudson facilitated the PAR group.

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1. Summary

This report describes the project 'Preventing Workplace Violence: Towards a Model for Best Practice in the Community'. The time frame for the study was February 1999 to February 2000. The aim of the project was to develop, implement and evaluate a model in one organisation with the view to the model's transportability to other community organizations. The objectives of the study were to (1) work with RDNS staff utilising a participatory action research (PAR) methodology (2) develop a model which can be implemented and evaluated throughout one service, (3) collaborate with similar community services in other Australian States who are prepared to trial and evaluate the model. An extensive review of the literature is provided in this report.

1.1 Objective one

A major goal of this project was to utilise a methodology that would involve staff, recognising that participation advances ownership and ongoing commitment of staff well after the project is completed. Although there are many collaborative research processes from which to choose, the methodology selected for this project was Participatory Action Research (PAR). We were guided by Kemmis and McTaggart's (1990) two crucial concepts of action research: the notion of group decision-making and commitment to improvement. Participatory action research is an interactive process, where knowledge is constructed through collaboration between the researcher and the respondents. Indeed, PAR participants are considered co-researchers in the enterprise of knowledge construction, and in this case, in model construction. This makes it an appropriate methodology to explore issues of staff safety and develop new strategies for staff security. Building on the commitment of staff to share what has been learned in the PAR process, consciousness raising is used to fashion a better understanding of workplace violence throughout the organisation, and members of the PAR are instrumental not only in the development of the model but in its implementation.

A flyer seeking expressions of interest was distributed throughout the organisation and community nurses were asked to volunteer. Nine community nurses joined the PAR group, which was facilitated by the first and second authors, and met every fortnight for 90 minutes beginning in early February 1999

Reviewing the 'violence literature confirmed that a model for violence prevention applicable to community practice did not exist. As there was no guiding literature, the first phase of the project was to discover what occurs in community nursing practice. At the first meeting of the PAR group, the concept of consciousness raising within was discussed, and the process begun. First, the community setting was defined as the client's home, the clinic, the office, the road and the pathways between these venues. All members of the PAR group collected stories from colleagues. Staff were informally asked: 'Tell me a community story or incident you experienced as 'violent'? This was seen as a consciousness raising exercise, both within the group and among field staff, and served to give violence in the workplace a previously neglected focus. In this way, sixty-eight (68) stories of violent behaviours directed at staff were generated, all anonymously given.

The PAR group heard each story, and discussed them, sometimes at length. During these discussions, it became clear that the construction of violence varied within the group. Even after much discussion, we could not agree on a definition, but we were able to reach consensus that violence was whatever the nurse telling the story felt it was and we would accept their construction. In this way, the PAR group used these stories to gain a better picture of violence in the community. The group used a slightly modified WorkCover SA definition of violence to guide their discussions that is: 'workplace violence is defined as '... any incident where an employer or employee is abused, threatened or assaulted in situations relating to their work' (WorkCover 1998:5).

In a preliminary analysis of the 68 stories, the PAR group noted that abuse/aggression accounted for 43 percent, threats 25 percent and assault/ physical violence 32 percent. We noted that many incidents had not been officially reported, reinforcing the view that underreporting is a common phenomenon, particularly when violence is experienced as abuse or threat. Abuse and threats in the community workplace are common and the stories confirmed that staff often deal with these as an everyday episode not seen as worthy of reporting. On the contrary, all episodes of physical violence were reported, except where the event took place many years ago, when reporting processes were not available.

In June 1999, all PAR group members participated in making a video. The content of the video was structured around Bowie's (1996) strategies and utilisation of the stories previously generated. Arrangements were made to reach all staff in this community organisation with the video and a prepared teaching package as part of the regular inservice program. Incorporating feedback from educational activities, consultation with management and ongoing conversation with PAR team members resulted in the development of Model for Best Practice in the Community.

1.2 Objective two

The Model for Best Practice in the Community consists of nine awareness and action options for RDNS staff to consider, they are; (1) at referral and triage, (2) assessment including four components: self awareness, self control, self preservation, and other awareness, (3) awareness of options if a violent event is experienced, (4) reporting the incident (5) support, (6) defuse, (7) debrief, (8), follow up and (9) moving on. Recognising that prevention is not always possible, development of strategies to minimise the effects of violence is an integral part of the model. The model relies on formal organisational structures and process to achieve its outcomes.

The model was implemented between July and December 1999. The success of the model and its implementation is entirely dependent on the supporting structures on which it is based. In this project, the organisation's Employee Safety and Rehabilitation (ESR) Committee provided an overview the project and was involved in the implementation and evaluation of the model. The literature is very clear about management involvement and support to enable policies and reporting mechanisms. This support, however, must be predicated on appropriate education of all staff, whether at orientation or as part of continuing updates.

An education package has been prepared for all nursing staff, designed to 'walk' staff through the model. Precisely because staff work a variety of shifts it was considered important to

develop an educational tool that could be accessed easily. In August 1999, PAR group members participated in making a second video explaining the model. The video is part of an implementation strategy and accompanied by a literature resource file and a written education package in each of the three RDNS regions. In addition PAR group members made themselves available to staff to discuss and advance interest in the model.

In November 1999, the organisation's senior management group ratified the model for use throughout the service. A brochure describing the model has been designed and circulated to all staff. PAR members will promote the model and its elements at regular staff meetings in addition to formal organisational meetings. The education package now forms part of the orientation program. Evaluation data are accrued through the ESR Committee information and organisational data (reported incidents of workplace violence). These data have been analysed, and it is noted that reporting has increased in the time span of this project. The ESR Committee, in their action plan for June 1999-June 2001, has incorporated the model's implementation and evaluation into this plan.

1.3 Objective three

As this project is a case study in one organisation, it can be extrapolated to similar community service enterprises both within South Australia, and nationally. Four community organisations were invited to review the model (1) Helping Hand Aged Care at Ingle Farm, Adelaide; (2) Royal District Nursing Service (Melbourne); (3) Blue Care District Nursing Service (Brisbane); and Blacktown, Mt Druit Health Community and Allied Health Service (Parramatta NSW). These services were asked questions around the model's usefulness and feasibility in terms of implementation. While the model's usefulness was agreed upon, implementation issues were raised. Issues related to the resources required for educational preparation and the model's modification for other settings. Blue Care would like to trial the model, and aspects of the model have been incorporated by other services. The stories told by staff resonated with the assessors. As one said 'the examples that staff of RDNS cited of experiences of workplace violence within the client's home situations I believe would be similar to the type of situations that have been reported by staff in our organisation'.

This report, which we view as one of the products of the study, can be further disseminated and although the entire model may not be suitable for individual organisations, we are sure that some aspects of the work reported here will enhance a community safety culture.

2. Preventing workplace violence: toward a best practice model for work in the community

2.1 Introduction

Workplace violence has gained increasing attention over the past two decades. International research, and data from government agencies such as Worksafe Australia, and the Occupational Safety and Health Administration (OSHA) indicate there is an growing risk of job related violence in a variety of industries. Health care workers generally, and nurses particularly also have had to confront this increasing problem in their workplace. Guidelines and protocols have been developed to improve worker safety and security; however, they usually rely on the implicit protection of other workers in the immediate vicinity, and the shelter provided by a geographically confined workplace. There is minimal help available to develop strategies for community based workers.

Workplace violence, in any form, as ‘part of the job’ is unacceptable. RDNS figures indicate an upward trend of reported violent or potentially violent incidents since 1992. However, we believe these data represent the ‘tip of the iceberg’. Under reporting has been identified as a major issue in the national and international literature.

This project challenges social attitudes to the tolerance of workplace violence. The general perception of this problem is usually restricted to physical assault. Verbal harassment, intimidation, expression of uncontrolled irritation, displaced anger applied unreasonably and abuse are not always considered violent acts. Like the term sexual harassment, which has now been brought into the public consciousness, what constitutes workplace violence is still not well understood and is seen as inevitable in particular jobs. Redefinition of the concept of workplace violence is necessary for employment in the community.

2.2 Literature Review

This review will scan some of the available literature in the area of client-enacted violence against community workers published in the last ten years. The literature variously refers to this increase as ‘endemic’ (Calvert 1996) in ‘epidemic proportions’ (Williams & Robertson 1997) and ‘a silent epidemic’ (Lybecker 1998). Variations on this theme can be found throughout the literature.

There is a prolific literature about workplace violence, yet few research studies have been conducted in Australia. A notable exception to this has been the recent work of Kappler (1992, 1993) who explored the issue in a broader sense, and Newhouse (1995) who examined workplace violence in aged care facilities.

A wide range of reports and conference papers has been useful in assessing this field. A significant difficulty, however, has been the confusion in the literature, and common parlance in defining terms. Questions about the meaning of the word violence, and the meaning of the phrase itself have served to ‘muddy the waters’ when searching the terms. Various countries and organisations have developed definitions to give explicit meaning to

the term. Lack of definition in the literature between the concepts of workplace violence and bullying has also added to the general confusion.

A CDROM search was conducted in CINAHL and Sociofile, using various combinations of keywords such as workplace violence, community/home health nursing, aggression, worker assault and abuse. The World Wide Web was also accessed to find relevant material. Two websites devoted to this problem have been developed, one each in the US and UK. In addition to the difficulties associated with defining terms, underreporting, and the criteria used by government agencies when compiling injury statistics due to workplace violence have created a literature which is not fully representative of the phenomenon. A wide array of material was located, ranging from newspaper articles to documents produced by government agencies such as Worksafe Australia, OSHA and the (US) National Institute of Occupational Safety and Health (NIOSH). Foci of the literature included discussions of violent acts perpetrated against workers, categories of workers at risk, factors which increase risk, the impact of workplace violence on nurses and victim support programmes. Other material explored issues of management response to workplace violence and development of systems, protocols and guidelines for prevention. The literature addressing workplace violence in the community is virtually non-existent; only two papers were found which examined prevention approaches from a district nursing perspective.

2.2.1 Definitions

There are many definitions of workplace violence. One definition of workplace violence is, 'physical assault, threatening behaviour or verbal abuse, and racial and sexual harassment occurring in a work setting' (Stanton 1993:6,7). Another, developed by the International Council of Nursing (ICN) has defined violence as 'being destructive towards another person', and abuse as 'behaviour that humiliates, degrades, or otherwise indicates a lack of respect for the dignity and worth of an individual' (ICN Brochure). Whereas the Worksafe Australia (1993) guidelines for the prevention and management of client aggression define workplace violence as 'hostile, unacceptable behaviour directed against staff by members of the public'. Clearly these definitions encompass both physical violence and verbal abuse. Until definitions are able to be discussed and agreed upon by the research team, for the purpose of this review, workplace violence is defined as '... any incident where an employer or employee is abused, threatened or assaulted in situations relating to their work' (WorkCover 1998:5).

2.2.2 Incidence of Workplace Violence

The incidence of workplace violence against nurses is impossible to determine. Many workplace violence episodes are not included in national workers compensation databases. In Australia, as in Canada and the US, incidents resulting in fewer than five days absence from work are excluded. However, this represents 46% of all new claims lodged annually. Another factor preventing accurate data collection is the non-reporting behaviour of nurses following a violent episode (Foley 1996; Lybecker 1998). The UK Health and Safety Authority has been reported as saying that nurses were five times more likely to be attacked than other workers. The same Authority said that other categories of employees at risk were social and care workers (BBC Online 1997). A survey in Canada described findings where 80 percent of nurse participants had experienced some form of violence in their career. Almost 6000 violent incidents were reported in the 12 months leading up to the survey (Cruikshank 1995). Another survey in the Accident and Emergency (A&E) department of a major Irish public hospital found that:

60% of nurses and attendants had been physically assaulted at least once while working in the A&E department and that 40% had been assaulted within the past 12 months (Rose 1997:216).

These results are similar to other research in the UK, US, New Zealand and Canada. Comparable work has been undertaken in Australia by Newhouse (1995) in one aged care facility, and a survey has been developed by a researcher in Queensland, although not implemented as yet (personal communication).

2.2.3 Workplace Violence in the Media

Since the late eighties there has been an explosion of written material in the general and professional press which addresses the issue of workplace violence. Some of these are reports of research (Yarwood 1993; Ballard 1994; Saidel 1997) while others are newspaper reports (Donaghy 1997; USA Today 1997). These research and newspaper reports are not confined to violence against nurses. Saidel (1997) says that 'most workplace violence remains hidden, those most at risk are women working in human services and that women victims of workplace violence are twice as likely to know their attackers. She added that amazingly, society, and the victim, often does not consider the violence to be criminal behaviour.

Websites such as NurseAdvocate, (Carrie Lybecker), and Bully OnLine, web site of the UK National Workplace Bullying Advice Line, (Tim Field) have been developed in response to the increase of violence against nurses, and others, in their workplace. NurseAdvocate, and other lists to a lesser extent, have been used by nurses. The NurseAdvocate ListServe was established to:

Discuss forms of violence including the historical and ongoing devaluation of nurses; workplace manifestations of violence; social and economic structures of personal and institutional violence; and, the immediate and long-term effects of violence against nurses (Lybecker 1999).

Nurse Advocate makes it possible for nurses to vent frustration and anger about what they see as an insurmountable problem.

2.2.4 Impact of Violence on Nurses

Crocker and Cummings (1995) say there are very few studies about nurses' reactions to violent episodes in the workplace. What little evidence exists suggests that many nurses minimise or even deny the assault and its effects. This is similar to the domestic violence phenomenon, where battered women often deny the experience, minimise its importance and defend the offender (Scutt 1990). Several psychological and behavioural reactions to assault have been documented. These include shock, anger and depression, flashbacks, insomnia, loss of trust, difficulty concentrating and changes in family relationships. A common, and well documented finding is that many nurses do not report violence. Various reasons are given for this including lack of information, belief that violence is part of the job, lack of clarity about reporting protocols and that patients/clients are not responsible for their behaviour (Crocker & Cummings 1995; Gage & Kingdom 1995; Foley 1996).

A less well documented aspect of workplace violence is the effect on those who observe the incident. Rees & Lehane (1996) in a study of 50 nurses who had witnessed a total of 23

incidents. His findings indicated that most participants had changed their work practices, they were more aware of the feelings of their colleagues involved in incidents. He writes:

This study has demonstrated that those witnessing violence can experience similar emotional difficulties as the victims of violence.... Male staff appear to have difficulty in accepting emotional support in the form of counselling...(Rees & Lehane 1996:47).

The reactions of nurses to workplace violence bear a striking similarity to that of Post Traumatic Stress Disorder (PTSD). This is a common diagnosis describing symptoms following an emotionally traumatic experience with a possibility of actual or potential injury or death, either personally or to others (Baldwin 1999). Grossman suggests that PTSD is a survival mechanism, and Baldwin (1999) agrees, saying that the symptoms of trauma are an adaptive mechanism, evolving to enable quick recognition and avoidance of danger. The domestic violence paradigm may also be helpful in understanding non-reporting, and other reactions of shame, embarrassment at being unable to control a situation and mistrust of management and colleagues. PTSD is not an inescapable response to violence; however, it is impossible to predict individual reactions. Level of reaction is unrelated to the severity of the incident. For this reason, adequate support mechanisms must be available for all involved individuals. This may well include family members. Grossman (1999) proposes early and intensive intervention and support, to prevent pathological responses. The major focus is on debriefing as an immediate response, and reassuring participants that their reactions are normal, and healthy

2.2.5 Prevention

The literature surrounding prevention is extensive, and helpful, for institutions. Several Government agencies - WorkCover in all the Australian states, OSHA, NIOSH have all issued guidelines for developing strategies for the prevention of workplace violence. They rely, however, on a confined geographic workplace. Elsewhere, a range of literature discusses prevention strategies, and the roles and responsibilities of management and staff (Carroll 1997; Simonowitz, Rigdon and Mannings 1997; Umiker 1997). One article was found which examined nurse safety in the community. The author proposes a range of strategies to reduce the risk of unprepared nurses visiting clients. This includes questions to be asked at referral and at the first visit. A 'Safe Environment Contract' and a 'No-Harm Contract' is suggested. Hunter also proposes an assessment scale for aggression, and treatment strategies for potentially aggressive clients (Hunter 1997).

Beale and Leather (1998) also propose steps to reducing risk to district nurses. They argue for a three pronged approach and suggest activities for employing bodies (in their case Trusts) work teams and individuals. These actions are all designed to reduce the incidence of client violence.

Cherry and Upston (1997) offer the most useful protocols for Australian community practice. This publication offers a wide array of practical advice and guidance. The authors cover areas including self-awareness, self-control and self-preservation, responding to actual and potential violence and what to do following a critical incident, and offer a guide for organisations. This invaluable document is arguably, the best of its kind in the violence literature, and one of the few offering guidance to community based workers and organisations.

Cherry and Upston (1997) identify several broad triggers for anger, eg fear, frustration, altered cognitive states, and a desire to manipulate or intimidate, among others. They also offer helpful advice about how to deal with a person whose antagonism is activated by these factors. They explore Bowie's (1996) nine strategies for coping with violence in some detail. These strategies, designed to assist, chiefly, workers in the youth sector, still have application to the, usually, less impulsive clientele encountered by district/community nurses, and other service providers, whose main target population is older.

Bowie (1996) discusses these strategies, or options, at length, under the headings of the:

- negotiated option
- leaving option
- no action option
- seeking back up option
- evasive self defence option
- surprise or diversion option
- blending option
- restraint option
- The fight option

While Bowie (1996) suggests that negotiation should be the first option, arguably an organisation with a community focus would prefer its staff adopt the leaving option as a first line of defence, in the interests of occupational health and safety. It must be acknowledged, however, that at times it may be necessary to negotiate the worker's way out of the house. In an extended analysis, Bowie (1996) discusses when, and when not, to use each of the options. He maintains that the restraint and fight options are a last resort. Clearly, there are times when these, and the other options are unavoidable, however, as Cherry and Upston (1997) point out, 'discretion is always the better part of valour.

Two other documents found to be helpful were Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers, produced by the US Government Agency OSHA, and Workplace Violence Awareness & Prevention produced by the Long Island Coalition for Workplace Violence Awareness and Prevention. While limited by their advisory and informational nature and by the heavy focus on 'in house' violence, nonetheless these documents both offered useful material. They contain advice about the need for threat assessments within the organisation, the development of 'response teams' and reporting mechanisms. They extend to providing sample hazard assessment and incident report forms. In addition, both documents provide an extensive listing of further resources. Undoubtedly, these are valuable to the North American reader, but less so for Australian conditions.

2.2.6 The Offender/s

There is an influential literature devoted to means of identifying a person with the potential to inflict violence in the workplace. Several sources have developed a 'profile' of characteristics suggested to be common among offenders. Typically these 'profiles include a wide range of behaviours which allegedly can be used to predict who may commit violence (Chavez 1999, Baron 1993, Kelleher 1997). While these lists share some similar indicators, there are also significant differences in terms of the range and scope of the characteristics.

Cherry and Upston (1997), and Bowie (1997) suggest that the only sure predictor of violent behaviour is a history of violence. Some interesting recent research has explored the relationship of self-esteem and propensity for violence (Baumeister, Heatherton, & Tice. 1993; Baumeister, Smart, L. & Boden, 1996; Bushman, Baumeister, & Stack 1999; Schütz 1999). These and other authors argue that there is a relationship between high self-esteem, narcissism and violent behaviour. Bushman, Baumeister and Stack (1999) also claim a relationship between media violence and aggressive behaviour. This research appears to have revisited the work of Bandura (1977, 1986) with similar results.

2.2.7 Conclusion

Nurses' responses to violence reflect their social and professional enculturation. It is impossible therefore, to explore the phenomenon in isolation. Violence is embedded in the cultural, social, professional, political and economic context of the time. A number of papers explore ways of identifying the early signs of, and preventing aggression (Bowie 1996; Cherry & Upston 1997; Cooper 1994; Gage & Kingdom 1995).

There is a broad consensus throughout the literature that the costs of workplace violence is not limited to economic impact, such as workers compensation (Morgan 1996). The costs of workplace violence extend far beyond inflicting physical and/or psychological harm on an individual. Families, friends, colleagues and management of an organisation are all impacted in some way. The functioning of an organisation can only be enhanced by a well-structured workplace violence prevention policy. This includes risk identification and assessment, educational programmes to assist staff in an escalating or violent situation, formal reporting mechanisms including unsafe conditions and a well funded and structured support programme to help deal with the aftermath of a violent episode.

Evidence from several countries indicates that nurses working in the community are at increasing risk of violence. While workplace violence in the acute, extended and aged care sectors has been extensively studied and reported, research addressing this issue from a community perspective is negligible. This project will be a small step in the direction of addressing this major gap.

3. Methodology

The main objective was to utilise a methodology that would involve staff, recognising that participation advances ownership and ongoing commitment of staff well after the project is completed. The methodology selected for this project is Participatory Action Research (PAR). Kemmis and McTaggart (1990) say that two crucial concepts are distinctive features of action research; the notion of group decision and commitment to improvement. Participatory action research is an interactive process, where knowledge is constructed through collaboration between the researcher and the respondents. Indeed, PAR participants are considered co-researchers in the enterprise of knowledge construction. Participatory action research is a potent methodology for achieving outcomes that are acceptable to the participants. In exploring issues of concern in this unique way, PAR group members will not only generate change strategies but also be instrumental in implementing change. This makes it an appropriate methodology to explore issues of staff safety and develop new strategies for staff security.

PAR creates the possibility for participants to be involved in decision-making in their environment and practice (Robinson 1995; Street 1995). Thus, when undertaking research about client initiated violence against community nurses and other workers, PAR is the methodology of choice. Its use has created new knowledge, which has been used to fashion a better understanding throughout the organization, and implement a change regime within an Occupational Health and Safety framework.

3.1 The Participatory Action Research Process

There is a variety of approaches to PAR but researchers have a common commitment to two elements of the process – participation and action. The approach we selected was guided by the work of Street (1995), so it is important to outline her approach. In addition other writers were influential to our thinking about PAR and we will show what those influence as they formed the principles guiding the research process.

Street (1995) has based her methodology on Kemmis and McTaggart's (1990) model of PAR. They perceive PAR as an action research spiral. This spiral, or corkscrew concept, demands continual reflection, and revision of the research plan if necessary, while maintaining impetus toward the final goal. The planning, action and evaluation steps of PAR are spiral in nature, and are supported by the group framework. This 'spiral' could equally well be described as a 'switchback'. It comprises many stages, as figure one shows.

Within this process, the first two stages of the spiral are the collection and review of relevant literature, as a precursor and guide to planning further research. However, it is after these two stages that conventional research differs from PAR. Conventional research establishes that a hypothesis requires testing (Roberts and Taylor 1998; Street 1995), whereas PAR is concerned with exploring the issues that the researcher and the participants consider important. Street (1995) advocates PAR as the methodology of choice, having the potential to give people an understanding of a given situation, as a precursor to creating change. Participants enter the research process expecting change; PAR allows the researcher to modify the research question and thus restructure the study.

Figure one describes PAR as a cyclical process of group questioning, reflection and action using a collaborative framework to orchestrate and implement change. Street maintains that the variety of interests, knowledge, skills and experiences that are brought to the group will influence the outcomes. Participatory action research is a methodology enabling critical and practical management of complex situations. Just as definitions of PAR differ according to where the emphasis is placed by various writers, so does the actual practice of PAR. Reason (1994:328) writing was appealing as he discusses PAR as a strategy with three main facets. These are:

- recognition of power relationships
- recognition of the value of 'the lived experience' of people
- empowerment of people through the process of constructing and using their own knowledge.

3.2 PAR Principles guiding this study

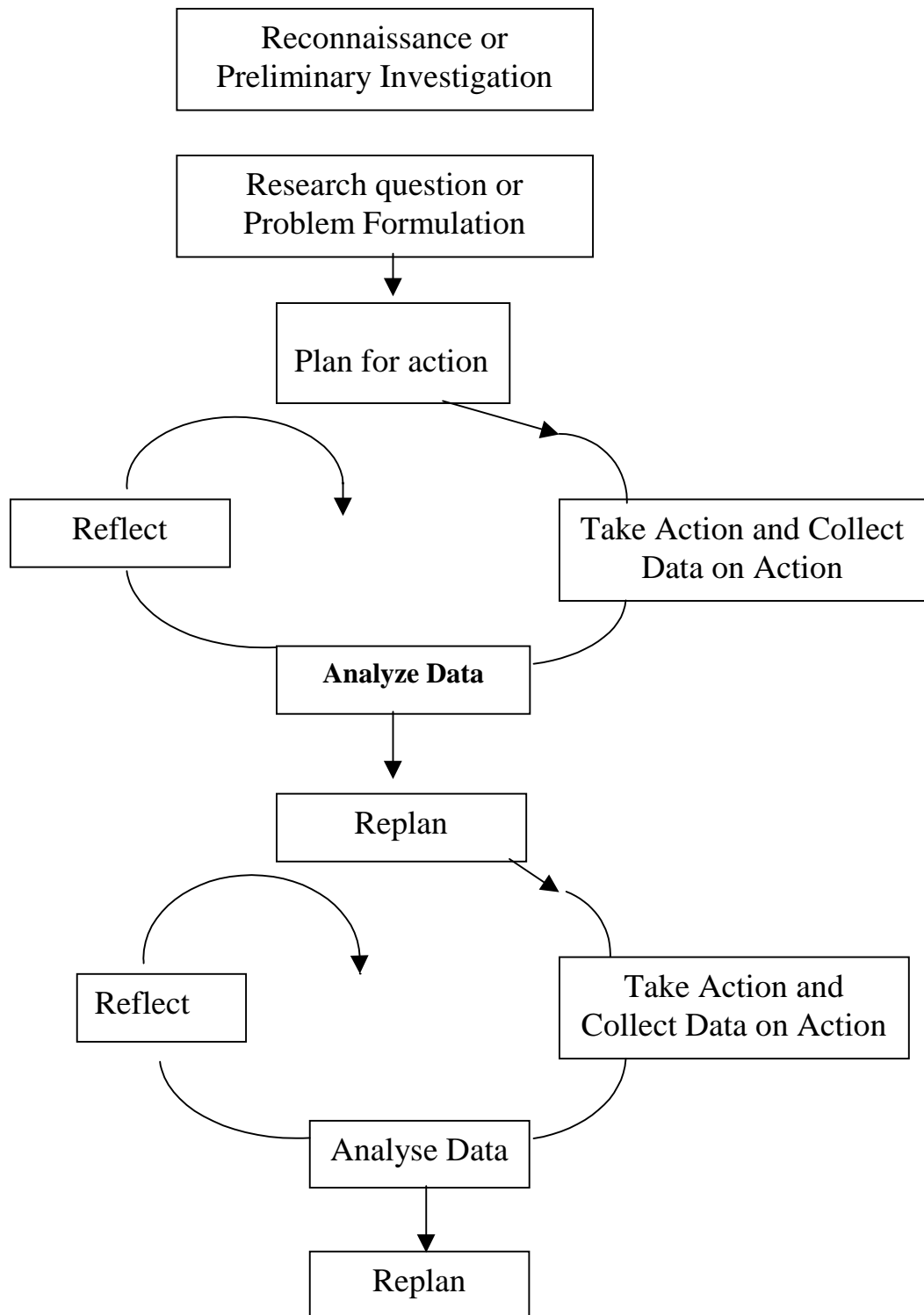
3.2.1 Knowledge development

The key to working with RDNS staff is valuing their experience and knowledge. Negotiation, compromise and consensus are fundamental concepts of PAR (Carr and Kemmis 1986; Hart and Bond 1995; Kemmis and McTaggart 1990; Street 1985, 1995). Fundamental to PAR are democratisation of knowledge development, and an emphasis on social change. Therefore, those affected by planned changes have the responsibility to decide which critically informed action will lead to improvement. It is essential, therefore, that all members take part in the research process. PAR maximises the potential to learn from the knowledge and experience of participants. This methodology offers the opportunity to develop a model to generate change, which has a practical application at individual and institutional levels.

3.2.2 Power Relationships

As previously noted, one of the fundamental postulates of PAR is democratisation of knowledge. Implicit in this is respect for the different knowledge each member brings to the group. A PAR group, ideally, is a meeting of equals. Theoretically, therefore, the issue of power differentials should not arise. Street, however, explicitly warns us to be mindful of power relationships, while Morgan (1995) explores some of the pitfalls of group work in a qualitative paradigm. According to Street (1995) one or more group members having a higher status within the organization can have an inhibiting effect on group functioning, through silencing or privileging various participants. Armed with these observations, we went into the PAR process mindfully.

The Participatory Action Research Process



(from Street 1995)

3.2.3 Setting the agenda

A major concept within this framework is that those affected by planned changes should decide the agenda (Kemmis and McTaggart 1988). Street (1995) suggests that as the group changes over time as an outcome of the exercise of critical and reflective thinking, so the questions will need renegotiation. Wadsworth (1998:16) supports this, saying that:

Change does not happen at 'the end' - it happens throughout. A hallmark of a genuine participatory action research process is that it may change shape and focus over time ... as participants focus and refocus their understandings about what is 'really' happening and what is really important to them.

Participants set the agenda, explore the issues and manage the changes deriving from the process (Carr and Kemmis 1986; Cruikshank 1996; Hart and Bond 1995; Street 1995; Stringer 1996). Armitage, Champeny-Smith, Andrews (1991), and Titchen and Binnie (1993) when conducting their research had already decided on the problem for group focus. In this project too, the issue of workplace violence had been decided prior to the formation of the group. In addition, we had three clear objectives to work through.

3.2.4 Emancipation and empowerment

A basic assumption of PAR is that power is a result of knowledge, and change is an outcome of power. The methodology draws on emancipatory, feminist and critical theories, taking the position that knowledge creates freedom (Lindsay and Stajduhar 1998). However, Greenwood (1994) cautions nurses undertaking PAR to be mindful of the profound effect of the emancipatory elements of participatory action research. The freedom evolving from ownership of issues, and empowerment of participants as they move through the PAR phenomena, permits the implementation and maintenance of change. Arguably, this can create discord within an organisation where the largest groups of employees have traditionally been relatively passive, accepting their position, and highly critical of those perceived to deviate from group norms. Within such a framework diversity must be valued (Lindsay and Stajduhar 1998). Negotiation must be carried out under circumstances where all parties are in possession of the same level of information. Constructions (eg what constitutes workplace violence?) are created through an interactive and dialectic process that include the evaluator as well as the many stakeholders. Teasing out the constructions that participants hold is the main task of the facilitator. Reaching consensus eg agreeing upon a definition of workplace violence is a good resultant example.

3.2.5 Role of the facilitator

Stringer's (1996) guidelines on the role of facilitator were particularly useful. A researcher, within the traditional paradigms, is an 'expert' doing research, whereas PAR has evolved to a point where the researcher is a 'resource' person and referred to as facilitator, associate or consultant. The PAR facilitator acts as a catalyst to assist participants to define their concerns clearly, and then support them as they find solutions. The facilitator can achieve this by using the following guidelines:

- Stimulate, rather than impose change. Encourage participants to change through addressing issues that concern them now.
- Focus on the way things are done, rather than in the traditional method of focusing on results achieved.

- Ensure that the process starts where people are, rather than where someone else thinks they are, or where someone thinks they ought to be.
- Assist participants to analyse their present situation, consider what they find and then plan for what parts they would like to keep and what they would like to change. However, it is not the role of the researcher to tell the participants what they should change or keep, but rather to respect and acknowledge the participants' ideas (Stringer 1996).
- Enable participants to view several options with the potential outcomes or consequences of those options. When the participants have selected an option, it is the researcher's role to assist with the implementation of the plan by identifying the pros and cons and then helping to locate the necessary resources.
 - Recognise that the ultimate responsibility for the success of the research centres on the participants. They need a feeling of 'ownership' and thus motivation to invest time and energy to change the status quo (Stringer 1996).

Soltis-Jarrett (1997) also examines power relationships in an extended discussion about the role of the facilitator. Titchen and Binnie (1993) say that facilitator flexibility is an essential component of the PAR process. Soltis-Jarrett (1997) describes the role of the group facilitator as one of guiding the conversations to share the balance of power. Soltis-Jarrett (1997) and Stringer (1996) agree that it is important for facilitators to share their values and beliefs, as this will lead to a greater collective understanding. This is one of the mutually educative facets of PAR. Koch (1994) maintains that the success of PAR relies on integrity and openness between all the group members. In this research project we were cautioned by the comments of Soltis-Jarrett (1997:47) who explored issues inherent in the facilitator's role under four 'philosophic aims'. These are

- the creation of a 'transformative milieu' to provide authority, structure and rigour
- illuminating reality to uncover the [cultural discourse]
- promoting resistance and accepting rejection ...
- reclaiming reality to maximise reciprocity ...

Using these aims, Soltis-Jarrett constructs a discussion around flexibility, group movement, exploration of cultural constraints, acceptance of other's positions and actions, and finally, the need for reciprocity within a PAR group.

3.2.6 Reflection

Street (as do all writers about this methodology) places emphasis on reflexivity as an integral part of the PAR process. Street (1995) and Kemmis, and McTaggart (1988) advocate that reflection takes two forms:

- A group process where the whole group reflects on what is learnt through the research process.
- Individual reflection, where the facilitator and participants reflect on the multiple facets of the research process.

In this project we selected the first form of reflection. We followed a process of collective and self-reflective inquiry to improve safety in the community workplace. Recording and reflection provides valuable information about group processes and group dynamics (Street 1995). For this project we recorded and transcribed all PAR and PMT meetings. Comprehensive notes were distributed for reflection and discussion at subsequent meetings.

3.2.7 Involvement of management

Having management involvement is obviously crucial to the success of the PAR process. Hart and Bond (1995) explore the importance of gaining management support for the process, arguing that undertakings of support for change are more likely to be honoured by negotiating structures and processes prior to establishing the PAR group. Our task for this research was to involve management through membership of a project management team (PMT) and ongoing formal communication with the Employee Safety and Rehabilitation Committee (ESR)

3.3 What can go wrong in the PAR process?

3.3.1 Setting the stage

In the light of her experience working with nurses for some years, Street (1995) offers some apposite remarks concerning PAR and this group of workers. She explores the need to develop positive research attitudes, within a culture which is notorious for "...structured institutional repression and violence" (Street 1995:62). The need to identify an area of concern common to the group is discussed in detail, with examples from her research practice. In a logical progression she then details 'the reconnaissance', as a process of unearthing relevant background and baseline material, and follows this with a brief discussion about reviewing the pertinent literature. 'Participant's accounts' and their accounts of the experiences of colleagues offers useful insights for the novice PAR researcher. With this idea firmly planted that we chose a consciousness-raising phase around the construction of violence to commence the inquiry.

PAR groups cannot operate in a vacuum. While the interest, expertise and commitment of group members is essential for successful functioning, high quality input into the group is a critical factor for the credibility of outcomes. Relevant literature, individual and group interviews, statistical data and group interaction are among fundamental aspects of successful process and outcomes of research using PAR methodology. In terms of reviewing pertinent literature, in preparation for PAR the Research Associate had prepared an extensive literature resource file for each region.

3.3.2 Whose interests?

Morgan (1995) in a helpful discussion highlights what can go wrong in the process, and ways to avoid the pitfalls. His prime concerns are adequate recruitment, avoiding problems relating to question guidelines, moderating techniques. He suggests that these concerns can be overcome by:

- attention to recruitment, using strategies to ensure participation, such as incentives, or sharing with the participants how important this research is to the wider group.
- selecting suitable participants for the area being researched to ensure that they are cognitively intact, and able to relate their life experiences.
- ensuring that the questions reflect the direction of the group rather than the interests of the facilitator.
- using a facilitator who can empathise with the participants, and who shares a similar background. The facilitator should not be dominant, preventing the voices of the participants being heard, or too passive, to ensure that the discussion is relevant to the research.

3.3.3 Negotiating at an uneven table

Stringer (1996) has summed up the principles of community based participatory action research. He maintains that relationships within the group must be equal, cooperative, sensitive and accepting. Group members' participation must be active, supportive and involving. Ideally, communication is attentive, truthful, sincere and advisory. The PAR process should account for all individuals, all groups, all issues, be cooperative and beneficial. Given the power inherent in the process it is essential that members are all willing participants, and are committed to the group and its activities (Robinson 1995). Being alert to power relations is vital in a cooperative research process. Unless the facilitators are mindful of these principles, the process can fail where negotiation takes place at an uneven table.

3.3.4 Sustaining the impetus for change

Stringer (1996) says that outcomes of the research are likely to be unproductive if constrained by time. Titchen and Binnie (1993) agree stating that the period for the project is critical, as change in practice is slow. Koch (1994) supports this, maintaining that the difficulty lies in sustaining the changes. Participatory Action Research methodology is a powerful means of harnessing the expertise and commitment of a small group of people to identify issues of concern, and work to create change. While change creation is a major strength of the process, it is also a weak link in the process. Koch (1994) acknowledges that organisational change is usually a slow process, and that maintaining momentum and interest is often difficult. Further, while the process of change creation is comparatively simple, individuals or groups can sabotage the process of amending organisational practice. Encouraging group members to maintain the links established during the life of the group through regular communication is one way of sustaining the impetus for change.

4. Participatory Action Research: This project

4.1 Recruitment

Participants were recruited into the PAR group via two mechanisms. Flyers were sent to each RDNS Region asking for expressions of interest (appendix 1). In addition, a notice was placed in the RDNS Exec Files; the fortnightly newsletter attached to all staff members' pay slips. Three staff members indicated their interest, and were invited to join the group. Three other staff members were approached in their capacity as Regional Health and Safety Representatives (H&SR). Two of these people immediately agreed to participate, however, the third suggested her proxy as an alternative. The Mental Health Clinical Nurse Consultant had shown an interest in the topic of workplace violence, so we invited him to join the group. As part of his role he receives and acts upon all reported incidents of client initiated workplace violence. This was another reason we were pleased that he agreed to become a PAR member. We also had additional expertise in the group, when we discovered that by fortunate coincidence two RDNS Harassment Officers were also members.

4.2 Group members

The Participatory Action Research group consisted of RDNS staff: Nona Dimmock, Graham Dunn, Maddi Crickmar and Di Mills (Northern RDNS Region), Elaine Tooke and Andy Kelly (Central RDNS Region) and Jenny Taylor, Fiona Smith and Jackie Rollins (Southern RDNS Region). Tina Koch and Sally Hudson (Research Nurse) facilitated the PAR group

4.3 Number of sessions

A time frame was prepared prior to commencement of the project and each member was aware of these program and time commitments. Two one-day workshop were planned for May and June. The group met every fortnight for 90 minutes, beginning in early February. Initially, the intent was to complete these by late August, with a final meeting in mid to late September, following distribution of the draft report. This was to provide the group with the opportunity to give feedback about the report.

4.4 Setting the agenda

Although PAR theory indicates that one function of the group is to set the agenda, that process was not followed for this project. There were several reasons for not following that pathway. The major reason, however, was that the project had been funded externally, to explore a specific issue. Given this circumstance, it was not considered possible to adhere to the recommended method of agenda setting. The issue of workplace violence was the topic of concern tied to three clear objectives.

4.5 Group facilitation

Facilitation of the groups tended to follow the accepted process. However, although the facilitator made every effort to maintain a collaborative process, this was not always possible. As with any developing group, issues of leadership, power and control became evident early in the group's life. While these were never overtly expressed, they were nonetheless apparent. On the other side of the coin, the group seemed to go through a 'passive' phase. This became particularly evident in late July, when most of the talking was left to two or three individuals. Again, the conversations were led in the direction of inclusiveness and equality.

4.6 At the first PAR session

Street's version of the action research and the principles of PAR were discussed at the first meeting. We agreed that the project's objectives were to assess, plan, implement and evaluate a model for prevention of workplace violence. We asked the following questions:

What is violence in a community setting?

What does this organization have in place in terms of formal reporting, policy documents, data collection and analysis.

How can we build on this?

Each PAR member then gave a biographical sketch. The facilitator asked each person to tell the group about an episode of violence in their practice. This was the first occurrence of consciousness raising. After each story there was often debate on the construction of violence. We realised that there were many constructions of violence but that we would respect the person's view. In the next fortnight the facilitator asked PAR members collect information from their own and other people's experiences. They were asked to systematically record, document and begin to analyze the stories. Particular attention was given to the reporting of the incident, whether the storyteller was aware of RDNS current policy and the outcome of the episode. The Research Nurse provided an overview of relevant literature on workplace violence and key articles were distributed (see extensive reference list). These were discussed at later meetings. PAR group members were guided to ask questions of the texts:

- Does the paper's intent have application in the community?
- What is the definition of violence in this paper?
- What is particularly useful in this paper for our project?
- What, if any, preventive strategies have been developed?

4.7 Defining the 'community'

As there was no guiding literature, the first phase of the project was to discover what occurs in the community. The community setting was defined as the client's home, the clinic, the office, the road and the pathways between these venues.

4.8 Consciousness raising

The first phase of the model development focussed on consciousness raising and communication of some key issues around the construction of violence. Having reviewed some of the 'violence' literature, we knew that a Community Model for violence prevention had not been developed. Work in this field relates to the acute and extended care sectors. It was clear that the group would need to develop a model specific for community practice. All members of the PAR group collected stories from RDNS colleagues. Staff were informally asked: 'Tell me a community story or incident you experienced as 'violent'? This was seen as a consciousness raising exercise, both within the group and among Regional staff, and served to give violence in the workplace a previously neglected focus. In this way sixty (60) stories of violent behaviour directed at RDNS staff were generated, all anonymously and

voluntarily given. Two stories took place at least 20 years ago, when the reporting and support mechanisms now available did not exist. Most were more recent, possibly within the last five years. At subsequent PAR sessions, the first hour of the meeting was devoted to telling stories and exploring commonalities. The story telling process was engaging for all concerned. Attendance was high for these sessions.

Stories are not data but it is possible to make some comment around common concerns raised. In these stories, the type of violence was interpreted as any incident where an employer or employee is abused, threatened or assaulted in situations relating to their work (WorkCover 1998).

4.9 Preliminary analysis of stories

In addition to the consciousness raising potential of generating stories it seemed worthwhile to use these stories to gain a better picture of violence in the community. We developed an analysis framework and categorised the episodes accordingly.

In the preliminary analysis of the stories, the PAR group noted that abuse /aggression accounted for 43%, threats 25% and assault/ physical violence 32%. Stories are not data but it is possible to make some comment around common concerns raised. In these stories, the type of violence was interpreted as any incident where an employer or employee is abused, threatened or assaulted in situations relating to their work (WorkCover 1998).

4.10 Common concerns raised

Even if the constructions of violence varied, it was recognized that the most important response was to acknowledge that the incident was significant for the storyteller. Often this was the first time the nurse had narrated the story, and on some occasions, being listened to was an act of validation.

It was recognised that many of the stories were not officially reported. Although it is difficult to give an accurate response to the reporting of incidents, the stories narrated suggest that underreporting is common, particularly when violence is experienced as abuse or threat. Abuse and threats in the community workplace are common and it was noted that staff often deal with these as daily occurrences not worthy of reporting. Rather they are absorbed in to the role of the professional nurse. However, all episodes of physical violence were reported except in cases where the event took place many years ago, when reporting processes were not in place. Non-reporting behaviour is frequently mentioned in the literature. In a major report, Worksafe Australia has explored this issue, and concluded that under or non-reporting is widespread among nurses, who tend to rationalise the violent behaviour of patients, clients or residents, unless they have been physically injured. Elsewhere, there seems to still be vestiges of the belief that either people who pursue nursing work must expect violence, or alternatively, the nurse must have provoked the attack (Lanza 1983).

A further reason for non-reporting emerged during the retelling of stories collected from staff in the PAR meetings. Trivialisation of the episode by peers and superiors was frequently cited as the reason for not reporting. This behaviour is also evident in the literature, particularly in the absence of physical injury.

As would be expected, most of violent acts against nurses took place in the client's home. It should be noted that clients with a history of violence are often referred to RDNS clinics, and eight of the stories were from clinics. This may have implications for safety and security of staff in clinics. The group formed the view, however, that episodes of violence were not confined to client's homes, and they were not random acts. It is often assumed that a staff member's risk of violence is increased when the nurse is exposed to new situations eg the first visit to the client in an unknown environment. Half the incidents reported in the stories were on first visit. This has implication for the referral and initial assessment process. The PAR group believed that the new RDNS call centre could have a role in vetting at referral for possible inclinations toward violence.

On five occasions, the client had a known history of violence, but the extent of that history was not disclosed at the time of referral. On each occasion, the referring agency had not informed RDNS about the threats or potential threats to their own staff. In addition to the moral obligation to inform others of the potential risk, there is arguably a legal obligation to inform. A legal precedent has already been set in another common law country (Republic of Ireland). Compensation was awarded to a plaintiff who suffered emotional injury resulting from the defendant misinforming about the nature of the risk (Kelly 1999).

In these stories, half of actual or potential violent events took place during subsequent visits to the client. Although the client may not be new to RDNS, often an inexperienced staff member encountered the client's violence. In addition to the safety preparation of new staff, this observation may have implications for the recording and alert systems currently in place.

RDNS gives particular attention to staff safety in the evening or at night, eg staff work in pairs on night duty and have duress alarms. It is therefore important to note that 80% of the potential or actual incidents observed occurred during the day. This observation could be skewed as many stories were generated from colleagues on day duty. Nevertheless, even if only half of the events happened during the day, there is a strong argument for extending safety measures to daytime hours. The PAR group was keen for management to explore the use of duress devices in the vulnerable settings eg clinics. In addition, the use of mobile phones can be employed in a different way to alert others.

Those who told their stories did not often discuss debriefing after the event. Several staff reported that their concerns for their safety were dismissed. One heated point of discussion in the PAR group was the practice of sending a second person (often a level three) to accompany the round nurse to the crisis. For PAR group members this meant that two people were at risk. On the other hand, one recommendation of many workers in the area of prevention (Cherry and Upston 1997; Bowie 1996) is to use the 'buddy' system when there are concerns about staff safety. The group felt, however, that this practice was inappropriate unless the second staff member had expertise in managing a crisis.

Many nurses seemed unaware of current organisational policy and process. The group noted that reporting after a violent event is unsystematic, at best. We recognised that the existing support structure for staff involved in a critical incident (comprising peers and management) provides an opportunity for defusing and/or debriefing and follow up if necessary. However, we believe that it is important to identify a specific person(s) to whom staff can report for this process. The process is dependent on staff reporting any incident, no matter how trivial they consider it to be. This strategy would require the organisation to develop tighter procedures

for reporting and follow up. This will also provide reliable data for monitoring developments following the implementation of the Workplace Violence Prevention Model in this area. It is important to bear in mind that this is a workplace injury issue, as well as workplace violence.

4.11 Bowie's strategies: Options for dealing with violence.

In reading the stories, the PAR group used Bowie's (1996) strategies for coping with threatened or actual violence as a guide to analysis. We gained permission from Cherry and Upston (1996) to use their work on strategies to guide our study. The counts and percentages shown are from the 60 stories generated and are rough guides gaining a better understanding what is happening in the community. These strategies are:

- The negotiated option (17 counts or 27%)
- The leaving option (8 counts or 13%)
- The no action option (14 counts or 23%)
- The seeking back up option (8 counts or 13%)
- The evasive self defence option (9 counts, or 15%)
- The surprise or diversion option*
- The blending option*
- The restraint option*
- The fight option*

* less than 2%

Although strategies can be counted as shown, these percentages serve only as a guide to the most frequent response. The stories suggest that the most common strategy used by RDNS staff for dealing with actual or potential violence is negotiation (27%). This is not surprising, as most staff believe they have a duty of care to see the client through the care episode. Here is an example of negotiation. The actual story is changed to protect the identity of the storyteller.

Negotiation

A man living in a boarding house needed wound management. I followed the client into the common room where the dressing was usually done, but found four men drinking, close to drunk. As I located the blue folder and dressings the men made lewd comments, suggesting they needed my care. I turned to the client and asked if we could go to another room. The men in the room were laughing. We went to the bedroom where the walls were covered with pornography. I felt just as uncomfortable in the bedroom so I said again that I wanted to use another room. He started to get annoyed with me. After all, the doctor had said I had to give him the care. While I agreed that he needed the nursing care I wanted to use another room. I suggested the kitchen or even outside on the verandah. He finally agreed and we went to the verandah.

Another option used is to leave the situation. This is certainly one advocated by RDNS ESR Committee, only 31% of staff responded in this way.

Leaving option

This was my first visit to this client. He has diabetes, severe arthritis and is in a wheelchair. The intention was that I draw up his insulin. Looking for the drug orders, I asked him where the blue folder and stock were kept. "Don't you know anything?" he said to me, grinding his teeth. "The stuff's on the table and the insulin is in the fridge. You're the first nurse that's had to ask that. What are you – a student?" I explained that never having been before I was didn't know where things were kept, but that on another occasion I would know. "God bloody help us" he said. I proceeded to draw up the insulin and I injected him. "What the hell do you think you're doing?" he yelled at me. I ignored him and continued. He had a grab stick in reach and pounded the table, barely missing my hand. "Please don't do that", I said, trying to appear calm. "It's my house and I'll do what I bloody well like" he yelled and banged the stick again. I got up, walked out of the room and left the house. I could hear him screaming at me as I got into the car. I didn't look back – but I needed to stop for coffee to calm down before I could see the next client.

The no action option is used frequently, again, this relates to the interpretation of the professional role of the nurse. Here duty of care is interpreted as seeing the home visit through to the end despite feeling unsafe and uncomfortable.

No Action Option

I was visiting a terminally ill client for palliative support and to fill his dosette. He lived alone and was increasingly confused about his medication. While I was filling the dosette I was trying to explain what the new tablets were for and when he needed to take them. He seemed frustrated. On this particular day he was upset about his nausea, as he said, ‘Katie, I don’t think it will ever go’. I explained that his new tablets may help the nausea but that they make take a few days to work. It all seemed too much. He swept the dosette and pills off the table in an angry swipe saying he couldn’t wait – that it was all hopeless. I calmly picked up the dosette and pills and began to refill the dosette. I spent some extra time with him to give him space to vent his fears and feelings.

Other strategies were divided among others listed above.

4.12 Further definitions of violence

One of the major difficulties encountered in researching the problem of workplace violence has been the definitional confusion surrounding the term. This confusion is an excellent example of the differences between Australian, British and US English. Therefore, we had to be very clear about which one of the myriad facets of workplace violence we proposed to address. The PAR group heard each story, and discussed them, sometimes at length. During these discussions, it became clear that the construction of violence varied within the group. When we developed the analysis framework we still had heated debates about definition. A definition acceptable to the PAR group was eventually negotiated.

There can be no doubt that a broadly accepted definition of the term is needed to enable discussion about the issue. Accepting a specific definition gave the issue a focus that is often otherwise lacking. Although not everyone agreed with the definition in its entirety, there were areas of consensus.

The WorkCover definition was subsequently modified slightly, so that the leading statement now reads:

Any incident or situation where a staff member is abused, threatened, or assaulted in situations relating to their work.

The group considered that by adding the word ‘situation’, and changing ‘employer and employee’ to ‘staff member’, greater flexibility could be achieved. The PAR group worked with this definition throughout the life of the project.

Clearly, the targets for a preventative intervention were the field staff of RDNS in the first instance. However, given that the model is intended for wider dissemination, it was important to bear in mind that the model and the interventions must have application for as many community based workers as possible. In addition to nurses, these include staff employed by Domiciliary Care, Helping Hand and other organisations whose staff work alone

in the community. Potentially, these could include staff of organisations such as Telstra, and power utilities ie gas and electricity.

4.13 Workshops

Early in the life of the PAR group we recognised that the strategies we wished to pursue would be impossible to accomplish in the planned fortnightly meetings. The group decided therefore, to set aside a full day in May to plan further activities, and to develop a beginning model for implementation in at least one region. This workshop was held in early May. The outcome of this workshop was a perception of much clearer direction for the group and its work. At this workshop a decision was taken to make a video for staff orientation and continuing education.

4.14 Education program

The video script built on stories and analysis the PAR group had completed. We included stories to show the way in which the assessment and referral phase was critical to a prevention model and used another seven stories to demonstrate Bowie's nine possible strategies for coping with violence. This video was made by the group in mid June 1999. All the PAR group members participated, each having a part on film. A range of scenarios was developed by a small group, based on the stories told to group members by other staff. These, then, became the script for the video, and were also included in the information sharing package. Unfortunately, during subsequent processing and editing, last minute computer software problems made half of the video unusable. Despite this, the group thought that it was important that the information sharing process went ahead. We retrieved what we could from the video session and although the work lacked an explanatory framework (this was wiped!) twelve stories were intact.

Arrangements were made with the Education Unit of RDNS for one group member with teaching experience to visit the three Regions with the video and a prepared teaching package as part of the regular in-service program. Each Region was visited twice, to give as many staff as possible the opportunity to participate in these sessions. One Region had an extra visit to accommodate the particular needs of the Enrolled Nurses in that Region. Attendance in one Region was extremely disappointing, while in the other two Regions, approximately half the staff attended. Reasons for the low attendance centered on pressures of work and the overriding demands of client care, which took precedence over further education. Everyone who attended the information sharing sessions received a copy of the package including the model.

4.15 Project Management Team

We established a Project Management Team (PMT), a requirement from the funding body, WorkCover, at the outset of the project (appendix 2 and appendix 3 includes terms of reference). Representation from both Helping Hand Aged Care, as another service delivery agency in the community, and the Australian Nursing Federation, to monitor industrial implications, was sought. The terms of reference for the PMT were to:

- Receive and consider recommendations from the PAR group
- Deal with the industrial and implementation issues as they arise
- Receive a monthly report from the PAR group
- Overview the project and time lines
- Keep external bodies informed
- Enhance the project's credibility in the eyes of external stakeholders, and interested parties

The PMT met regularly each month to discuss the status of the project and to keep it 'on track'. Team members have also disseminated information about the project and its progress throughout their own organisations, and brought information to the meetings.

A major contribution of PMT members was a continual check on the model development, to ensure its transferability to other community organisations. This awareness assisted with the project's third objective which was to collaborate with similar community services in other Australian States who were prepared to trial and evaluate the model.

Checking the model for transferability was important as not all organizations have the infrastructure and established committee structures available to RDNS. Moreover, the wide diversity of community agencies, both in South Australia and elsewhere, who may use the model made it imperative that the model be as generic as possible. The PMT made every effort to keep a focus on the model's evolution.

When the PAR group decided to make its first educational video, the input and assistance of Michael Kelly, from the Department of Administrative and Information Services was particularly valuable.

5. Toward a Model of Best Practice

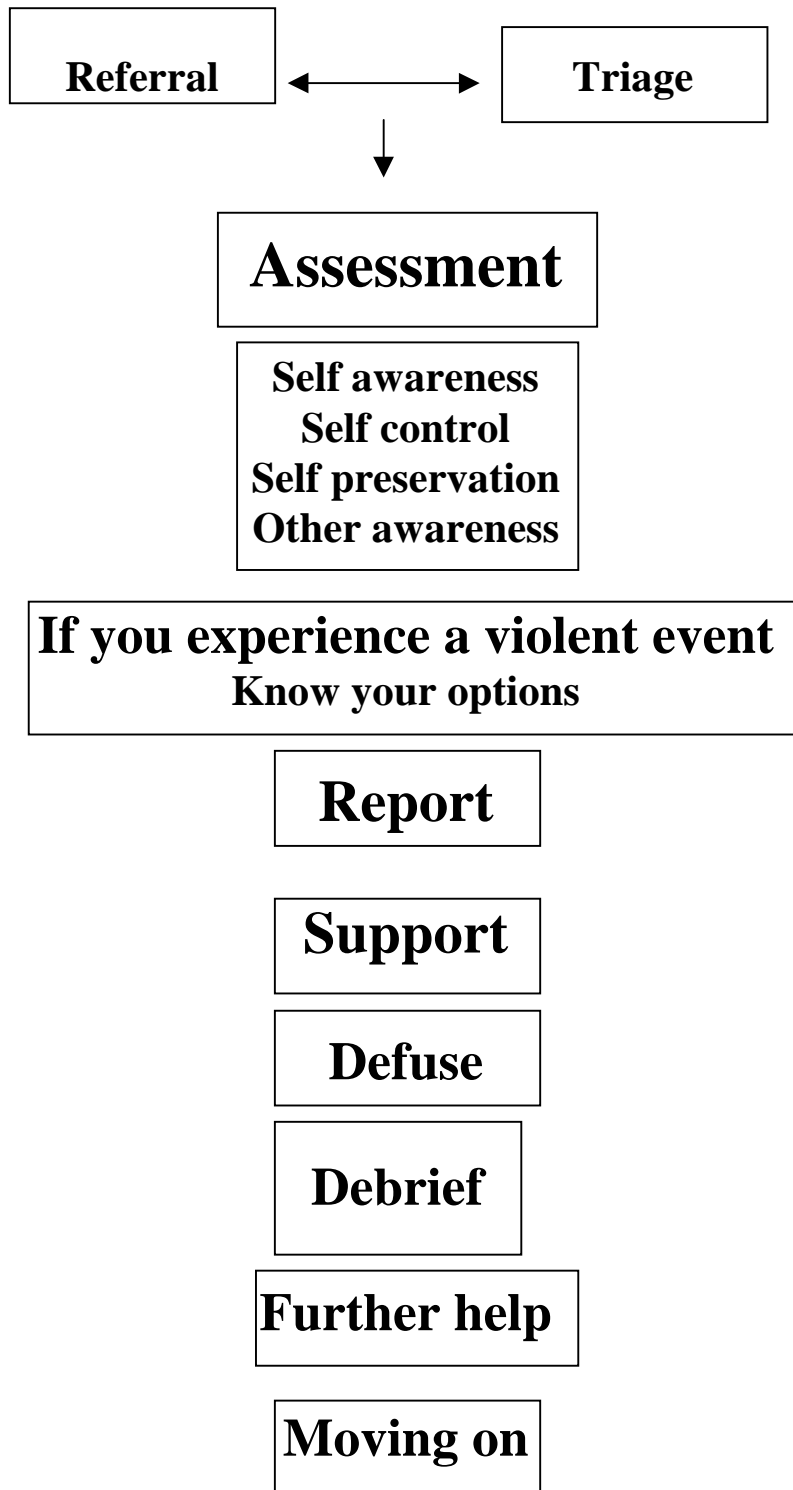
This project has developed a model for preventing workplace violence enacted by clients against nurses (workers) practicing in the community. Participatory action research methodology has been utilised to achieve this end. A review of the literature showed that although the incidence of client enacted violence has increased worldwide, there was little published material, either electronic or paper, relevant to district/community nursing practice. While there is a substantial literature surrounding the issue only two articles addressed the particular needs of this group of nurses (workers). A PAR group was established to develop a model specific to community work. While the needs of nurses were uppermost in their minds, the ability to transfer the model to other groups of community based workers also informed our work.

Objective two was to develop a model which can be implemented and evaluated throughout one service. Tina Koch facilitated the PAR discussions, while Sally Hudson recorded the proceedings, searched for and delivered relevant articles to the PAR group and assisted with the development of the model. Tina assisted with identification of issues and instituting problem solving mechanisms within the PAR group. The PAR group reviewed current RDNS practice on managing workplace violence, current literature, recent RDNS ESR documents relating to workplace violence, and reviewed recent publications from various state and federal departments with an interest in these issues.

As discussed, an important document produced by Cherry and Upston (1997) was instrumental in guiding deliberations and the final form of the model. An RDNS colleague provided this document. After several weeks attempting to extract relevant information from influential US government documents, and blend this into a coherent whole, the group decided to seek permission to adapt an extant Australian document to meet the conditions peculiar to this community service.

The model evolved as the PAR groups continued. The model (presented below) consists of nine awareness and action options for employees to consider: (1) at referral and triage, (2) assessment including four components: self awareness, self control, self preservation, and other awareness, (3) awareness of options if a violent event is experienced, (4) reporting the incident (5) support, (6) defuse, (7) debrief, (8), follow up and (9) moving on. Recognising that prevention is not always possible, development of strategies to minimise the effects of violence is an integral part of the model. The model relies on formal organisational structures and educational processes to achieve its outcomes.

A BEST PRACTICE MODEL FOR VIOLENCE PREVENTION IN COMMUNITY WORK



As can be seen, the model has several features:

- Referral
- Triage
- Assessment
 - Self awareness
 - Self control
 - Self preservation
 - Other awareness
- Knowing your options (Bowie's strategies)
- Reporting
- Support
- Defuse
- Debrief
- Further help
- Moving on

Some of these features are based on the document by Cherry and Upston (1997) who gave permission to use and modify their work for this project, and Bowie (1996) who developed a range of strategies to deal with violent situations. The element of 'other awareness' developed from recognition that there is minimal attention paid to the need to assess clients for cues suggesting that they may be in a volatile state, often a precursor to violence. A second educational video has been made by the PAR group to accompany this model. The model is articulated as follows:

5.1 Referral

Clients are referred via the RDNS Call Centre from a variety of sources - eg Domiciliary Care, GPs other community agencies. Many are self-referred. It is important to vet the information from the referral source for potential safety hazards. It is suggested that one the following questions be asked of referrers:

Is there any reason to think that this person or others in the house pose a threat to the safety of our staff, bearing in mind that our nurses mostly work alone?

Is there a safety hazard, history of violence or challenging behaviour that you know about that can pose a threat to the safety of RDNS Staff?

These routine types of questions may suitable for clients referred by other health or human service agencies.

5.2 Triage

Triage is an established process within RDNS but this type of vetting may not be practicable in other organisations. Triage is the next process in the RDNS referral chain when a team of registered nurses vet information and make decisions about who will see the client and when. Clients who are self, friend, neighbour etc. referred could be dealt with as part of triage. At

this stage, it is often possible to make further inquiries before the visit goes ahead. This involves contacting the client's GP and asking the same or similar questions. For example:

Dr. Mack, a Mr. Fred Brown has referred himself/been referred by a friend/neighbour to us. As part of our workplace safety policy, we ask other providers if they know of any reason to think that this person or others in the house may pose a threat to the safety of RDNS staff.

In addition, this has the advantage of early contact with the GP. This would be noted on the form sent to the admitting team. It may be appropriate to contact other community agencies to establish whether they know the referred person. Following triage and acceptance, the referral is sent to the appropriate team for admission.

5.3 Assessment

Triage and acceptance is followed by the first visit and client assessment. The word is deliberately highlighted in this manner, indicating its importance. Assessment is the cornerstone of nursing practice and the overarching activity in providing nursing care. This is also an opportunity for assessing and preparing for personal safety. We already assess for physical hazards, and ask clients to modify their environment as part of the care process. Assessment of potential for violence is no different, but requires another set of assessment skills. Under assessment we have identified four key aspects: self-awareness, self control, self preservation, other awareness. The first three of these four elements are taken from Cherry and Upston (1997). However, they have been extensively modified for work in the community.

5.3.1 Self awareness

Self-awareness is a vital aspect of preventing a violent incident from occurring. Concepts within the element of 'self awareness' include:

- willingness to notice and pay attention to your own feelings, thoughts and actions
- trust in your feelings to alert you to a need to be fully conscious
- attention to 'gut feelings'
- making time to explore 'feelings' in safety

However, assessment of clients' potential for violence is far too important to rely only on gut feelings and certainly needs a comprehensive assessment tool.

- Self-awareness is a state of knowing yourself. To develop this, you must be prepared to examine themselves openly and honestly, and be able to accept what you find
- Self-awareness means awareness of your own values, prejudices, fears and emotional and anger triggers, likes/dislikes, bias, knowledge, skill, ability and previous learning.

Knowing yourself means that you can harness and utilise the attributes, knowledge and skills you possess. It allows you to take conscious steps to counter elements that may limit your safety or effectiveness in a given situation. For example, knowing that you get fearful and paralysed when a tall male yells at you, means that you can plan strategies to support yourself when you know this situation is likely. Knowing that you are slow at getting to your

feet when you have been kneeling or squatting on the floor means that you can choose consciously to never put yourself in this position in situations that may be hazardous.

In addition, knowing that you have good, excellent or poor verbal and /or physical self defence skills, allows you to make sound conscious choices about the supports you will need to ensure your safety in any given situation. If you are aware, you notice, and can respond more appropriately to cues. You are able to respond to these cues by immediately acting to ensure your safety. When you are in a position of safety, you are more able to determine the best course of action. Lack of awareness means you are more likely to miss, ignore or react inappropriately to the person or situation, potentially creating or increasing the hazard to yourself or others.

5.3.2 Self control

The ability to maintain conscious self control in a threatening situation, is vital for your own and others' safety. Many of us practice for emergencies such as fires, bomb alerts or using ABC skills for resuscitation for cardiac arrest. Few of us rehearse for situations involving violence, although it is a situation we are much more likely to experience. We would do well to rehearse self-preservation methods in situations involving violence. Rehearsal promotes self-control and calm when the anticipated violence does occur. Rehearsal and self-awareness permit us to respond (conscious fresh choice) to crises rather than react (unconscious, re-enactment of past solutions). Concepts within the element of 'self control' include:

- anticipation and preparation
- rehearsal and practice
- responding (conscious, fresh choice versus reacting)
- remaining conscious
- learning how to become centred, calm and focused

Self-control relies on self-awareness. By being aware, you may choose how to respond to crises. This makes the later need to defend or document behaviour much easier, and enables the development of sound problem solving strategies.

One of the strategies in self-control is centring. This strategy can help to maintain self-control in a way that is calm and focussed, and creates a state of personal strength. It allows clarity of thought and judgement, providing a stability of posture and emotion. You can move into a state of calm, clear, responsible readiness.

Above all, try to appear CALM! Your manner may prevent a situation from escalating.

Even if you do not feel calm, try to appear relaxed and in control of yourself and the situation. You can do this by using a firm, clear tone of voice, not yelling and speaking in short, simple sentences.

5.3.3 Self preservation

Self preservation includes identifying risk factors and minimising risk to your personal safety. You can do this by consciously observing, noting and addressing hazards and consciously adapting your actions to the hazard. Self assessment for vulnerability, a continuous hazard monitoring in your workplace, and a continuous hazard monitoring in your own work practice, all promote self preservation.

5.3.3.1 Before the client encounter: Personal Self Preservation Strategies

Constant awareness allows you to perceive hazards, to notice them, and to put plans and actions into place to avoid or address them. In maintaining personal safety, we must learn to be aware of our own vulnerability. For example, ask yourself:

- What skills and knowledge do I possess?
- Am I having difficulty staying focused because I'm worried about some external event or stresses?
- Do I feel unwell and weak
- Am I carrying an injury?
- Does this person evoke anger in me that is difficult to control?
- Do I feel like a victim? Do I tend to construct negative scripts for myself or my client. For example:

I've got to see Mr ... again today. He'll probably be really abusive and difficult again. I just can't cope with his horrible behaviour

Before the first visit, ask:

- What are the organisation's policies and guidelines for working in the community and for managing, reporting and recording hazards and/or incidents?
- Have I entered the police emergency number / RDNS office number into the auto dial list of my phone? Do I know who to ring?
- What are the duress arrangements?
- Am I aware of this person's specific needs? Be prepared to be flexible to enable the most desirable response from a client. Some clients will have specific needs for service; eg timed calls, ring first, back door only etc.
- What is there to know about the client and the client's environment?
- Is there an alert in the clinical records? RDNS Has an asterisk system for hazard alerting.
- Who can I speak with about this person?
- Have the referral questions relating to your safety been answered?

5.3.3.2 Some practical strategies:

- Carry out continuous actual or mental safety audits. Look for hazards (and help) on the way to and from home, work and client locations. Check each street, road lane or car park you use. Audit the immediate surroundings each time you stop the car at lights, client's house or at office carparks.
- Audit each work area for entrances, exits and other people, animals or things that may injure you, or that you can call on for your own defence.
- Stand back from and to one side of the door after knocking at the client's house, while remaining visible to anyone looking through the peephole
- Ask permission to enter the house
- When going in the door of the house try to let the client in before you if they are outside.
- Check the locks on the door as you walk in. Secured deadlocks or chains will make any escape impossible should a difficult situation arise.
- Assert your rights and insist that doors behind you remain unlocked while you are visiting.
- Make a mental note of the exits as you walk into the house.
- Be aware of specific protocols that may exist for a specific client, eg exact appointment times or a joint visit.
- Carry your mobile phone, with the battery charged, into the house with you. Even if you have to lock yourself in the toilet for safety, you are still able to call for help

IF YOU BECOME CONCERNED ABOUT YOUR SAFETY WHILE VISITING A CLIENT AT HOME LEAVE AS QUICKLY AS POSSIBLE.

- Keep your car keys with you in the client's house. A key ring that attaches to your belt is a good investment in your own safety. It also ensures that you never have to go searching for your keys.
- If there are people hanging around your car, stay away from the vehicle. Move to a safe place and summon police.
- Check the spaces you must walk through to get to your car, workplace or house.

5.3.3.3 Organisational

- Implement a referral system that identifies potentially violent situations associated with a client or a residence.
- Make other service providers aware that you expect to be advised of known (or likely) potential or actual violent situations associated with a client
- If hazards are associated with other people or animals in the client's environment, the exclusion of these from your workplace should be a condition of service
- Issue each field staff member with a duress alarm, or an equally effective means of summoning immediate help. This may mean that day staff are also monitored by the security firm, in addition to evening and night staff.

5.3.3.4 In the Clinics

- Ensure that clinic premises have at least two doors to allow escape if the need arises.
- Install duress alarms to the nearest police station or security firm
- Ensure a second person is available as necessary (buddy system)
- Monitor the use of clinics as a ‘dumping ground’ for clients who have a history of violence.
- Develop contingency plans for clients with a history of violence eg clear appointment times and/or the presence of two people

5.3.4 Other awareness

The element of other awareness evolved out of the work of the PAR group. It refers to the need to be ‘other/s’ focussed during the assessment and care process. It means picking up subtle cues that may indicate a potential for violence. Cherry & Upston (1997) devote some space to reasons/causes of anger. Bushman and Baumeister (1998) discuss elevated levels of self-esteem. There is also a view that the best predictor of violence is a history of previous violence (Cherry and Upston 1997).

Other awareness is an extension of the assessment we already undertake. It requires, however, different thought processes and analytical skills, but most importantly observational skills. Observation of anger eg clenched fists, tense facial muscles, rigid body posturing and a loud angry voice, menacing gestures eg fist shaking, hitting objects and slamming doors etc are some cues for violence potential. Other more subtle cues may include hand tremor in the absence of eg Parkinson’s or thyroid disease, and voice tremor. However, unless the assessment is ‘other’ focussed in addition to complaint focussed, these cues may be missed.

5.4 Know your options in a situation of violence

This section is an acknowledgment that despite the best efforts, violent episodes may still occur. This is not an endorsement of the popular view that many acts of violence are spontaneous, random and unpredictable. It is, however, recognition that cues have been missed.

BOWIE’S STRATEGIES FOR COPING WITH THREATENED OR ACTUAL VIOLENCE

- The negotiated option
- The leaving option
- The no action option
- The seeking back up option
- The surprise or diversion option
- The blending option
- The evasive self defence option
- The restraint option
- The fight option

5.4.1 The negotiated option

Bowie suggests that negotiation approaches should be done in a calm, easy style, speaking as to a friend or equal, not expressing or showing, fear, anger or contempt. Ideally, try to negotiate a win-win outcome with the client.

A male client, who was known to RDNS for his violent history, had signed a contract of care, with clear appointment times. This contract required two nurses to be present while he received nursing care. One day he arrived at the clinic an hour too early for his appointment. I was on my own. I asked him to come back at his appointment time. He left, and came back at the appointed time. On another occasion I opened the door to find the client had arrived at the clinic without an appointment and asked if I could see him. I closed the door and locked it. Talking through the door, I reminded him about the contract he'd signed and the two nurse arrangements. He left and did not come back. Reported

5.4.2 The leaving option

When in a situation of violence or threat of violence, RDNS prefers its staff to use the leaving option. Before leaving, consider what must be done to escape and how to reach the nearest place of safety. Try to leave as a positive action rather than a panic reaction. Leave when in a situation that seems unsafe.

I was in a client's home dressing his wound. He started to criticise what I was doing, and the way I was doing it. He began to get quite abusive about the hospital he'd been in previously, and the care he'd received since coming home. Agitated, he moved his leg around, making it impossible for me to start the dressing. The yelling, insults and his use of foul language made the situation untenable. As he continued to be abusive and threatening, I stood up and said that I was leaving. He became even angrier then and threw the blue folder at me as I was leaving the room. Fortunately I was able to get out without being physically hurt. I don't *ever* want to go back into that house. I didn't report this.

5.4.3 The no-action option

This is a deliberate choice of action in order to achieve a later, more favourable situation. The time to use the no-action option is when you need to wait until the situation becomes clearer, to see if it will improve. Alternatively, use no-action when confronted with weapons, or by an assailant on drugs or who is mentally disturbed, and realising that your actions might jeopardise others' lives (e.g. displacement of violence onto others).

I was visiting a terminally ill client for palliative support and to fill his dosette. He lived alone and his condition was deteriorating. While I was filling his dosette I was trying to explain what the new tablets were for and when he needed to take

them. He seemed confused and frustrated. On this particular day he was upset about his nausea, and he said, 'Katie, I don't think it will ever go'. I explained that his new tablets should help his nausea but that they make take a few days to work. It all seemed too much For him. He swept the dosette and pills off the table in an angry swipe saying he couldn't stand it any more – that it was all hopeless. I calmly picked up the dosette and pills and began to refill the dosette. I spent some extra time with him to give him space to vent his fears and frustration. Not reported.

5.4.4 The seeking backup option

This is an option for you to seek help in dealing with an aggressive client. It is used to provide help and expertise. It may also be used to provide better protection or 'strength in numbers' when you feel vulnerable. Calling for backup may involve the use of concealed alarms, coded messages or other means of getting appropriate backup. In some situations you may have to physically call out for support.

I was visiting a client in a block of flats. I parked the car in the allotted space and had a short walk through a garden to the flats. As I approached the flats I could hear someone walking behind me. I looked around and saw a man turn around as if he was walking in the other direction. I felt a bit scared, so I hurried on a little. As I located the flat – it was upstairs, I saw him again, standing between the stairs and me. He must have gone around another way to the back entrance (I won't use that way because it's too dark). He asked me what I was doing there. I said that I was a district nurse and was here to see a client. He asked me who I was visiting and I said that I could not tell him that. I asked him if he was going up the stairs. He stepped out of the way and I went up to the flat. While I was in the flat I looked out of the window and could see him still hanging around. I asked the client if she knew who he was. She didn't. He was still there when I'd finished with the client, so I rang the police. Reported.

5.4.5 The surprise or diversion option

Surprise or diversion is a sudden change of mood, focus or direction. The objective of surprise or diversion is to interrupt the attacker's train of thought or action, confusing them and/or re-focusing their attention on something else. This may create an opportunity for you to take control of the situation and/or escape. Using humour can sometimes also be a useful distraction as long as it is not used in a sarcastic or demeaning manner. You may be able to initiate a surprise or diversion by feigning a collapse, unconsciousness, a fit or a heart attack.

An experienced female nurse was referred to initiate a DNCB assessment of elderly Australian woman. The client's son let the nurse into the house, down a long passageway into the room where his mother was sitting. She was in a state of physical neglect ie sores on legs, emaciated, wearing urine stained nightgown. The nurse did not comment on her appearance and started the DNCB assessment. As the client was deaf the nurse had to raise her voice in order to be heard. It was at this point that the son came up very close to the nurse's face and shouted very loudly; "Don't you speak to my Mother like that" . He then grabbed hold of the nurse's ID badge and said in a menacing voice; 'so you are Mary! I'll remember that name. You'd better be careful'. At this stage the nurse was petrified. Fearing for her safety she tried to think of a way to distract him as he paced up and down the room muttering to himself angrily. Again he came up close to the nurse in a very threatening manner and said, 'You tell that bloody social worker if I ever see her again I'll garrotte her'. Just then a large cat entered the room and the nurse commented on it. **She said, 'What a beautiful cat ...Is he yours?'** This seemed to distract the son and he calmed down and began talking about the cat. Mary seized upon this opportunity, and told them that she had finished the assessment. She was then able to quickly leave the house.

5.4.6 The blending option

The aim of blending is to re-direct your energy so that you have joined forces with the other person and you are able then to move in the same direction. It can be used effectively for both verbal and physical attacks, with the type of blending required defined by the situation. The worker ends up physically or emotionally alongside the assailant rather than in opposition. This unexpected blending of forces may surprise or unbalance the attacker, this gives the worker the opportunity to take control or flee immediately. Blending is an active alternative to no action when more time to plan is needed or the time to act has not yet come.

None used this strategy

5.4.7 The evasive self defence option

Bowie suggests that Evasive Self Defence (ESD) is only used in order to enable a worker to avoid personal injury or to escape from a dangerous situation. It should be used in the least intrusive way possible and not drawing undue attention to the incident. Negotiation should be used whenever possible alongside ESD. We generated many stories but not one that exactly fits this option. However you may like to consider this story.

An older man in a wheelchair requires daily insulin injections. RDNS staff call on a daily basis. He has been receiving the service for eight years. His wife lives in the same house but in separate section as there is a history of domestic violence. She has left him for a short time, but she has since returned on the proviso that she is no longer involved in his care. The nature of his violence is described as daily doses of abusive language and swiping at the nurse as insulin is being given. Despite his sedentary position, he has strong arms. One of the strategies employed by RDNS is to go into the house, say as little as possible, give the insulin and leave. However, it is felt that this client misses out on comprehensive care as a result of his aggressive behaviour. . Reported. The RDNS service has been withdrawn on a number of occasions.

5.4.8 The restraint option

The Restraint option is complex and controversial. Ineffectual or inappropriate attempts at restraint may cause more damage to the worker and client than the initial aggressive behaviour. It is used only when all other methods are inappropriate or have been tried and failed.

None used this option.

5.4.9 The fight option

Fighting is a last resort, in order to save life or avoid injury. Difficult personal judgements need to be made about the level of force to be used in order to save self and others from attack that is perceived to be life threatening. Complex judgements about duty of care and the legal requirements of "reasonable force" to defend against attack, vary from service to service, and state to state.

One Sunday morning I visited an older man needing tracheostomy care – which involved him lying on his , with me bending over to dress around his stoma and give him a new bib. As I was finishing the care and I had my face close to his, he grabbed my shoulders and tried to kiss me. I overbalanced and fell onto the bed partly on top of him. He held me down and kept kissing me. I was outraged and yelled: “Stop! Stop! Let me go. How dare you”. He paid no attention and started to grope me. I struggled and he laughed. I pushed hard against him and managed to get free and get away. I ran to the door and out to my car. I was very shaken up. Thinking about it later I wished I'd blocked his trachy off with my hand, but I doubt whether I'd really do that. I didn't report it. This happened many years ago and at that time it was not expected that you reported. You just managed, that was it.

5.5 Report: After a violent episode

A simple flowchart showing steps to be followed after a violent episode has been developed. The 'Report' box is quite deliberately highlighted. This is one of the most important elements in the model. In the absence of reporting, it is impossible to gauge the prevalence of violent incidents. Underreporting is frequently mentioned in the literature as a common problem, both in Australia, and internationally. Certainly Underreporting seems evident from the information the PAR group has gathered. It is crucial that all incidents are reported, no matter how trivial they may seem to the nurse.

5.5.1 Reporting

It is expected that each member of RDNS knows the process and reporting procedures. That is:

- What to do after an event
- Who to contact after an event
- Choices available (defuse, debrief, counselling etc)
- Formal written documentation reporting the event
- Entry into the nursing notes so that others are alerted
- 360 degree reporting mechanisms.
- Storage and retrieval of reported incidents
- Organisation's responsibility for analysing and reporting these data
- Evaluation of process and procedures

5.6 Support

Following a report of violence, the support and defusing process is activated. One specific person or a team may be selected, depending on the choice of the individual nurse. This is usually a team, including the nurse manager (immediate supervisor) the H& SR, and one or more peers. The structure needs to be flexible to meet the needs of all individuals. The function is to provide support and an opportunity for the injured party to defuse.

This process can educate staff and management about workplace violence, and influence cultural norms within the organisation. Peer support groups have also been suggested as a means of helping staff members through a difficult period. Such a group can be influential in reducing a 'blame the victim' response. USA research (Lanza & Carifio 1991) indicates that women who have been assaulted are blamed more than men, and 'the nurse must have done something wrong'.

Depending on the extent of the trauma, support and the opportunity to defuse may be enough to minimise the effects of the violent attack.

5.7 Defuse

According to Cherry and Upston (1997), the purpose of defusing is to contain the violent event, and to help those involved recognise that it has finished. Defusing also enables assessment for further debriefing or other follow up. Typically, a defusing session is held as soon as possible after the event – ideally within 12 hours. It will take between 20 minutes to

one hour, and could involve everyone affected by the incident. Defusing is not limited to a single person; several may be involved in a violent incident as bystanders, and depending on individual response, may welcome the opportunity to defuse. A line manager, a staff member or any other responsible person with expertise in the area who has the trust of those involved usually provides defusing. Depending on individual response, this may be adequate, and the person/people may be able to move on.

Post incident defusing, debriefing and counselling, promptly delivered, can reduce acute stress levels for victims and witnesses.

Usually a brief report will be compiled following the defusing session, which outlines the event, the circumstances and the effects on those involved. Proposals for further action should also form part of the report. Participants must give their consent for such a report to go forward to management.

It is important to re-establish normal work patterns as soon as possible. Unless time off work is necessary, evidence suggests that maintaining a normal routine as far as possible is beneficial. Contact with colleagues, who can provide support, is also a helpful strategy. It may be necessary to modify work patterns for a period, and institute a supported return to work program for a staff member who has been physically or psychologically hurt by a violent incident.

5.8 Debrief

If the defusing process is not enough for the person, help must be made available for a more formal debriefing process. This should be undertaken through the Employee Assistance Program. It should not be a role of staff members within the organisation no matter how well qualified. This is a specialised area of expertise, and a person requiring this help needs a different relationship than can be available within a workplace/collegial environment. The function of debriefing is to speed recovery for those involved in a violent event who experience normal stress following the abnormal event. It also provides an opportunity for individuals to process the event, rather than explore issues connected with the event, which is the purpose of counselling. According to Cherry et al (1997:30) debriefing:

- provides information after the event
- clears up misunderstanding and dispels myths about the incident
- allays fears of negative personal reactions
- helps people regain a sense of control
- encourages people to use their own resources to cope.

Ideally , debriefing takes place 3-5 days following an event, however, in case of a coroner's hearing or a funeral, further debriefing will usually be necessary following this event.

At an appropriate time, the person should be followed up using the 360° turn around process. This creates the opportunity to assess for closure and readiness for moving on, whether further help is needed and the type of help best suited to the circumstances.

5.9 Further Help

Just as people respond differently in similar circumstances, so the support mechanisms must be individually tailored for each person. Defusing and debriefing are not always sufficient on their own. . Under certain circumstances eg if reactions increase rather than decrease, or if an individual has had a previous trauma which was not well handled, referral for in depth counselling is indicated. Such a referral is not an indication of failure on the part of the individual, or of the post event strategies. It is, however, recognition of individual differences in response and healing times.

5.10 Moving On.

When the defusing and debriefing stages have been successfully worked through ,and no feelings of inadequacy or blame linger, the individual will move on.

This model has been the basis of educational preparation. An abridged version is found in appendix 4. Employee Safety and Rehabilitation The next phase of the project is the model's implementation.

6. Implementation

In September 1999 an interim report was produced, corresponding with the content pages 1-44 of this report and distributed to each PAR group member, the Project Management Group, and the organisation's ESR committee. In addition WorkCover was sent the report. The content of the report was used to guide staff education, to allow PMT members to ascertain the model's transferability to other organisations, but most importantly, to facilitate the model's journey through the organisation's administrative system toward implementation.

Members of the PAR group in collaboration with the Project Management Team (PMT) had a central function in facilitating and communicating the PAR research process within and external to RDNS. They were responsible for creating a forum for raising industrial and implementation issues. In addition, individual members of the PAR and PMT were expected to accept responsibility for representation for a specific work group, establish and maintain a communication network regarding the project's progress and issues raised. The PAR group reported monthly to the PMT.

In August 1999, PAR group members participated in making a second video the content of which explained the model. It was designed to 'walk' staff through the model. Precisely because staff work a variety of shifts it was seen as important to develop an educational tool that could be assessed easily. So the video is part of an implementation strategy, accompanied by a literature resource file and a written education package in each of the three RDNS regions. In addition PAR group members made themselves available to staff to discuss and advance interest in the model. This was the second education package prepared for all employees.

PAR group members were active in promoting the model throughout the organization. The Research Nurse presented the model at Regional Meetings and the video and an educational package and resources were left in Regional Offices.

6.1 Gaining Administrative Sanction

A deliberate decision, taken when the concept of exploring the issue of workplace violence using PAR was mooted, was to invite the Regional Health and Safety Representatives (H&SR) to become members of the group. The presence of the H&SRs as group members ensured that the organisational Employee Safety and Rehabilitation (ESR) Committee was kept informed of progress of the work.

Between early July and August, each Region was visited to share information about the project. Arrangements were made with RDNS Education Department as part of the regular ESR updates. The major message delivered to staff was "report" any incident they perceived to be violent.

In August 1999, Professor Tina Koch, as the PAR group facilitator, was invited to the regular meeting of the ESR Committee to present an interim report outlining the model, discuss the research, and answer any questions.

At the August 1999 meeting the ESR committee was requested to

- adopt our definition of violence
- assist with the implementation and evaluation of the model
- have recording structures and processes in place.

Subsequently, the ESR Advisor was requested to add violence statistics to the monthly report of incidents and injuries. This request was to be taken to the Employee Safety and Rehabilitation (ESR) Committee for their approval. This Committee was informed that the model, video and supporting documentation should be available for their meeting in September.

At the September ESR meeting, the model, with an explanation of all the elements was provided. The following recommendations were put to the ESR committee that:

- the RDNS ESR accept and implement the model as soon as practicable.
- the second educational package (video and documentation) introducing the model is used for RDNS staff for orientation and continuous education. The organisation is asked to view this education package for use throughout the organisation.
- the ESR Advisor, and the Regional Health and Safety Representatives to promote the model as a whole.
- a review of policies, structures, processes and procedures as they relate to workplace violence is undertaken
- a specific person be identified as the initial contact person in the event of a violent incident, along the same lines as the Regional Harassment Officers.
- flexible response teams be established which can be activated in the event of a violent incident.
- the referral module on the CVMS (RDNS client recording system) be modified to include questions to be routinely asked of referrers.
- an alert system is explored eg a dedicated button be identified on the mobile phones, which is tied to the call centre, and creates an alert. Suggestions have been made that this could be routed through a geographical tracking system on the cars.
- improved interagency communication be pursued. Other referring agencies must become aware of our expectations regarding information, and conform to these.
- funding be sought to enable this model undergo formative and summative evaluation in the near future.

The Committee undertook to consider the model and to discuss it at the October meeting.

At the October 1999 ESR meeting, the model was formally accepted and the next stage was its presentation at RDNS Senior Management.

In November 1999, the Senior Management Group ratified the model for use throughout the service. PAR group members made themselves available to staff to discuss and advance interest in the model.

The recommendations from the interim report have been incorporated in the RDNS Employee Safety and Rehabilitation (ESR) management system action plan (25.10.99) The ESR

Committee, in their action plan for June 1999-June 2001 has incorporated the model's implementation and evaluation into this plan. In addition, a brochure describing the model has been designed and circulated to all staff (appendix 5). PAR members will promote the model and its elements at regular staff meetings in addition to formal organisational meetings. The education package now forms part of the orientation program.

The Best Practice Model was implemented with the PAR group, the PMT, RDNS Education department and the ESR Committee. Together they created a process for managing educational preparation, implementation and evaluation of the model. Preventative and ameliorating strategies have been articulated within the model. A strong emphasis has been placed on reporting any incident, regardless of how trivial it appears. The success of the model and its implementation is entirely dependent on the supporting structures on which it is based. Regardless of quality, the administrative and educational supports are pivotal to success. The literature is very clear about management involvement and support to enable policies and reporting mechanisms. This support, however, must be predicated on appropriate education of all staff, whether at orientation or as part of continuing updates. Education of staff must go past discussion of the ESR structures within a given organisation. Attention must also be paid to teaching especially field, and call centre staff, methods of identifying cues which may be a precursor to violent behaviour, and the means of de-escalating the situation.

6.2 Evaluation

Evaluation data are accrued through the ESR's Committee information and organisational data (reported incidents of workplace violence). These data have been analysed and it is noted that reporting has increased in the time span of this project. The ESR has a fixed item on the Committee agenda which requires it to examine incident data their analysis on monthly basis. In this way it is possible to track the impact of the best practice model.

Incident and hazard report data analysed from 1992 to September 1999 are reported here. Current and past RDNS data were analysed, and showed an upward trend, from 28 reported violent episodes in the financial year 1992/93 to a high of 133 reports in 1997/98 financial year. Given the reality of underreporting, it was reasonable to think that these represented only the 'tip of the iceberg'. Interestingly, in the nine weeks since the information sharing sessions began, reports of violent episodes have escalated in number and as a proportion of all incident/hazard reports. This result is a further justification for thinking that underreporting was the norm within the organisation.

6.2.1 Table 1 Indicents reported

July 1998 to December 1998	January 1999 to June 1999
267 reported incidents	241 reported incidents
46 reported incidents with elements of violence	45 reported incidents with elements of violence

Total incidents for financial year 1998/99 508

Total incidents with elements of violence for financial year 1998/99 91

6.2.2 Table 2 Types of incident

INCIDENT	NUMBER	INCIDENT	NUMBER
Aggressive dog/bite	7	Aggressive dog/bite	6
Loitering	5	Abuse client/carer/other	7
MotorVehicle theft/damage	4	Aggression client/carer/other	7
Aggresive* client/carer/other	10	Threat	5
Abusive client/carer/other	5	Sexual	5
Violent history	7	Violent history	2
Assault	4	Weapon	4
Sexual	3	ETOH/drugs	5
Weapon	1	Miscellaneous**	4
TOTAL	46	TOTAL	45

* Includes 2 episodes of client using O2 and smoking

** Includes locked door behind nursing staff, no double asterisk on call sheet, 1 loitering, 1 theft of a private motor car

July to September 1999

150 reported incidents in the first ten weeks of 99/00

45 reported incidents with elements of violence in the first ten weeks of 99/00

6.2.3 Table 3 Reported Incidents

INCIDENT	NUMBER
Aggressive dog/bite	10
Loitering	1
MV theft/damage	3
Aggressive* client/carer/other	6
Abusive client/carer/other	6
Violent history	2
Assault	3
Sexual	7
Security/theft	3
Weapon	1
ETOH/drugs	3
TOTAL	45

* includes 2 episodes of clients smoking

As these tables clearly indicate, the reporting behaviour of staff has undergone a marked change. The 45 reported incidents with an element of violence in ten weeks is half that of the whole of the previous year. There has been a steady upward trend in these years. The most recent data, for the quarter July to October 1999 indicates the success of the PAR group message to report all incidents that can be construed as violent. The reported incidence of violence for less than three months is approximately half of the reports for all of 1998.

This increase in reporting behaviour clearly demonstrates the early success of the information sharing process. The increase assumes even greater significance given that attendance in one Region was extremely disappointing, and in the other two Regions approximately half the staff attended. Not surprisingly, the greatest number of reports came from the Region showing the greatest enthusiasm for the education sessions. It is an unfortunate reality, however, that change in reporting is often difficult to sustain. The work of the Health and Safety Representatives in the Regions is crucial in maintaining the reporting momentum begun in this way.

The tight time frame (one-year) for the project impeded an in-depth evaluation and this is a shortcoming of the process. A democratic process such as the PAR process is time consuming. However, as staff gave their own time and commitment voluntarily, the impact of the process reverberates not only within their own preventive practice but it has also influenced those with whom they work. Designed to reach all staff from below through the PAR group process and from above through the ESR Committee, workplace violence prevention has been raised to the conscious level of practitioners. Its sustainability is

dependent on continual staff development, the model as core content of orientation programs and as an organisational imperative to drive the prevention agenda. Further evaluation must occur in 2001.

7. The model's transferability to other organisations

In response to the third objective the model's transferability needs to be tested regarding extrapolation to similar community service enterprises both within South Australia, and nationally. Four community organisations were invited to review the model (1) Helping Hand Aged Care at Ingle Farm, Adelaide; (2) Royal District Nursing Service (Melbourne); (3) Blue Care District Nursing Service (Brisbane); and (4) Blacktown Mt Druit Health Community and Allied Health Service (Parramatta NSW). These organisation were given an abridged interim report to review (approx pages 1 to 43 of this report). These services were asked questions around the model's usefulness and feasibility in terms of implementation. Whilst the model's usefulness was agreed upon, implementation issues were raised. Issues related to the resources required for educational preparation and administration and the model's modification for other settings.

Helping Hand Aged Care (Adelaide) found the model to be useful but reported that small agencies may not have the resources to enable implementation of some aspects of the model eg GPS on cars. The model would have to be tailored to meet that organisation's specific needs. It was acknowledged that one of the key aspects of implementing a new model (or parts of it) is the educational preparation of staff.

Royal District Nursing Service (Melbourne) found the content of the interim report to closely parallel their process. The assessor reported that the work is useful as a theoretical background to that organisation's policies and procedures on the reporting of injury, hazards, managing road rage and abuse / harassment in the client's home, and critical incident debriefing / counselling. Whilst the overall model was viewed positively, there were some aspects of the process with which RDNS assessor was not comfortable:

- The first relates to the vetting of clients who either self refer or whose family or friends refer. This action is considered a breach of privacy and confidentiality if the referral is discussed with the GP before admission and without the consent of the referee.
- The second is the inclusion of all Bowie's nine options for coping with threatened or actual violence. Here the assessor advocates that it is reasonable to expect staff to be familiar with and use the first four options. The inclusion of the remaining options, culminating in actually restraining a client, may set an unrealistic expectation for staff to 'hang in' and not exit a potentially violent situation.

In addition to the comments above, the assessor suggests a process we may like to include. She writes that RDNS (Melbourne) has a process in place which requires the staff member to report, and the line manager to support and arrange appropriate counselling / debriefing, but also to manage the problem with the harasser / abuser. This has to be done promptly, with confidentiality and in a fair and equitable manner both for the staff member and the alleged harasser / abuser.

This assessor agrees that staff education is integral to the four awareness / self-preservation strategies and to the options for coping with threatened or actual violence. Although the

education packages (including the video) were not assessed by external agencies, this seems an opportunity to share the teaching modules across sites.

Finally, RDNS (Melbourne) reports that substantial systems are already in place within that organization, however, the assessor thinks that the framework and the process of decision making would be useful for other community based organizations to adapt to their own situation.

Blue Care would like to trial the model. The trial would depend on the allocation of resources necessary to undertake the education and training of staff. Implementation would require the model's modification eg Blue Care does not have a Call Centre or a formalized triaging process. The stories told by staff resonated with Blue Care as the assessor said ' the examples that staff of RDNS cited of experiences of workplace violence within the client's home situations I believe would be similar to the type of situations that have been reported by staff in our organisation'. It would be useful to 'hear what strategies staff employed to handle these situation'. In addition it would be useful to be able to provide staff with the educational preparation for facing potential situations in the future.

The assessor from Blacktown Mt Druit Health Community and Allied Health Service (Parramatta NSW) found the interim report 'an excellent resource and very readable, and appropriate'. The vignettes served to highlight practical situations and the discussion on possible strategies and solutions were useful. The model 'could be adopted for our service but for it to be successful would required someone with dedicated time to implement and provide/facilitate education'.

In conclusion, this report needs further dissemination for comment from external organisations. All assessors were from community nursing organizations and it is important to test the model with other types of services. The model will continue to evolve as further comments are considered and incorporated. Although the entire model may not be suitable for individual community organisations, we are sure that some aspect of the work reported here will enhance a community safety culture

8. References

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APPENDICES

- 1 Expression of interest**
- 2 Project Management Team (PMT)and Participatory Action
Research (PAR)group**
- 3 Terms of reference project management team**
- 4 The model: an abridged version**
- 5 Brochure to RDNS staff**