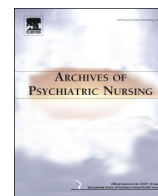




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Health Care Workers' Experiences of Aggression

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ABSTRACT

PRIMARY OBJECTIVE: To identify the prevalence of patient aggression against health care workers, the consequences and coping mechanisms.**DESIGN:** Retrospective cross-sectional design.**SUBJECTS:** 50 participants comprised 37 nurses, 1 ward staff, 12 allied health staff employed in two brain injury wards with experience ranging from 3 months to 34 years.**SETTING:** Neurosciences and Brain Injury Rehabilitation wards of a metropolitan tertiary hospital in Brisbane.**MAIN OUTCOME MEASURES:** Researcher designed self-report questionnaire.**RESULTS:** 98% of respondents had experienced aggression during their health care careers with an average of 143.93 events. Physical injuries had been sustained by 40% of staff, psychological injury by 82%, but only 12% sought treatment. Verbal aggression related to receiving a psychological injury ($r = 0.305, p < 0.05$). Experiencing one type of aggression made it more likely the person would also experience the other types of aggression. Verbal aggression was correlated with physical aggression ($r = 0.429, p < 0.01$) and non-verbal aggression ($r = 0.286, p < 0.05$), and physical aggression was correlated with non-verbal aggression ($r = 0.333, p < 0.05$). The majority of staff used informal debriefing with others as their main coping strategy which was considered effective.**CONCLUSIONS:** Patient aggression is prevalent and of serious concern for staff working in hospital settings.

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INTRODUCTION

Violence in the Australian health care system has been recognised as a serious concern, with nurses often subjected to aggression whilst performing their duties (Morphet et al., 2014; Swain, Gale, & Greenwood, 2014). Nurses are subjected to aggression from a variety of sources but patients have been cited as predominant instigators (McKinnon & Cross, 2008). In one study, only 14.9% of nurses reported feeling safe in their role at work (McKinnon & Cross, 2008). Aggression can be defined as behaviours involving destructive acts towards individuals or property, behaviours, attitudes or moods that others perceive as threatening, and/or purposeful acts to disrupt treatment (Wood, 1990).

High rates of aggression against nurses are well documented in the literature. Morphet et al. (2014) investigated experiences of aggression in the previous year in Australian hospitals by surveying 157 nurses employed in emergency departments. Physical assault was the most common form of aggression (74% had experienced it), followed by

verbal abuse (72%), threats of physical violence (29%), spitting (28%), and property damage (25%). Similarly, Swain et al. (2014) found that out of 227 healthcare workers 93% had experienced verbal aggression and 65% had experienced physical aggression in the preceding year by patients. Furthermore, 65% of staff had been humiliated, 56% had witnessed destructive behaviour, 38% of staff reported they had been physically assaulted, 43% had an attempted assault, and 10% had been sexually assaulted. The authors found that nurses were most commonly aggressed against, followed by doctors and clinical support staff, and then allied health staff.

The consequences of workplace violence against health workers includes physical injury such as scratches and cuts, bruises, muscle tears and fractures (McKinnon & Cross, 2008) and psychological factors such as lower commitment to the organisation, increased psychological distress, decreased job satisfaction (Demir & Rodwell, 2012), stress (Gates, Gillespie, & Succop, 2011), insomnia, anxiety attacks, low self-esteem (Jones & Lyneham, 2000), feelings of sadness, shock, confusion, anger and embarrassment (Reininghaus, Jamieson-Craig, Gournay, Hopkinson, & Carson, 2007). As a result nearly 10% of nurses change their work environment (O'Connell, Young, Brooks, Hutchings, & Lofthouse, 2000). Some acts of aggression are so serious that they require medical treatment (O'Connell et al., 2000). The majority of nurses do not report all incidences of aggression, citing the main reasons as

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dissatisfaction with management follow up and thinking the incident/s were not serious enough (McKinnon & Cross, 2008). Most nurses used verbal debriefing and communication to self-care and cope with aggression (O'Connell et al., 2000). The focus of aggression towards nurses in Australia has been in emergency departments or psychiatric units, with other hospital units being relatively neglected, despite high aggression potential.

It is increasingly recognised that as a result of a brain injury, cognitive, behavioural and emotional changes occur, with aggressive behaviours typically emerging or increasing in at least 25–35% of cases (Baguley, Cooper, & Felmingham, 2006; Rao, Rosenberg, Bertrand, et al., 2009). Acquired brain injury (ABI) is the main disabling condition for Australians under 65 years of age (Australian Institute of Health and Welfare, 2007).

Visscher, van Meijel, Stolker, Wiersma, and Nijman (2011) found 388 acts of aggression by inpatients with an ABI occurred during a 17 week period (44% were verbal, 56% were physical), with 67% of these being classed as minor, and the remainder being rated as severe. The majority (77%) of aggression was directed at staff, with 48 different staff members reporting it, highlighting how many people were affected by the aggression. Aggressive behaviours lead to unique problems within the neurosciences and rehabilitation settings, compromising safety, increasing vulnerability and reducing opportunities to engage in rehabilitation for the aggressor (Ciurli, Formisano, Bivona, Cantagallo, & Angelelli, 2011). Additionally, hospital staff may be emotionally or physically affected by aggressive incidences, resulting in extended sick leave, burnout, and staff attrition, hence creating a greater cost to the hospital and the community (O'Connell et al., 2000).

It is clear from previous research that hospital staff (especially nurses) are exposed to an alarmingly high amount of aggression in their working environments and staff in brain injury wards are potentially at even higher risk of this. The majority of research in this area fails to include non-verbal aggression, and either focuses on the prevalence of aggression or the consequences of aggression, rarely examining both. As such, research that is inclusive of more facets of aggression is justified and worthy of investigation.

AIMS

The current study aimed to identify the prevalence, consequences and coping mechanisms following patient aggression against health care workers in wards caring for brain injured patients. For the purposes of the study, aggression was operationalised as verbal threats, physical attacks against self, others, or objects, and non-verbal intimidation and was measured throughout the health care workers career.

HYPOTHESES

Based on the results of research previously reviewed, a series of hypotheses were generated.

1. There would be a high prevalence of aggression, with at least 70% of staff experiencing it in at least one form.
2. Psychological injuries would be more prevalent than physical injuries.
3. The majority of staff who experienced aggression would not seek treatment for any injuries.
4. Most respondents would use debriefing and verbal communication as their main coping strategy after experiencing aggression.

METHOD

PARTICIPANTS

Participants consisted of 50 staff from a neuroscience ward (where patients were usually first admitted following a brain injury) and a longer term rehabilitation ward of a metropolitan hospital in Brisbane, Australia. They were recruited through information sessions for nurses, ward staff, and allied health professionals. The voluntary participants

comprised 37 nurses, 1 ward staff, and 12 allied health staff. Their ages ranged from 21 to 61 years ($M = 33.93$ years, $SD = 10.04$ years). Eighty-two percent of the respondents were female ($M = 33.97$ years, $SD = 10.40$ years), and 18% were male ($M = 33.77$ years, $SD = 8.87$ years). The years of experience working in their field ranged from 3 months to 34 years ($M = 9.04$ years, $SD = 8.10$ years). The number of qualifications held by respondents ranged from none to three ($M = 1.16$, $SD = 0.47$). Approximately 107 staff were eligible to participate, indicating a 47% response rate.

DESIGN

The design was retrospective cross-sectional. Questionnaires were utilised to collect information from the participants. The study was based on participants' recall of aggressive incidences that had occurred during their career, and the effects that these acts of aggression had on them.

MATERIALS

Information was presented to staff as a group in the wards. A confidential locked box was available for completed questionnaires to be deposited into. The staff completed an informed consent form, followed by the researcher-designed questionnaire to measure the amount and the effects of aggression throughout their careers. The questionnaire enquired about whether the participant had ever experienced patient aggression; what types of aggression they had experienced; how many times; if they had ever been physically injured as a result; if they had experienced psychological symptoms; if they sought treatment for their injuries; if they had days off work due to aggression; if they considered other job options; how long it took them to recover emotionally from aggression; how they coped with aggression and whether their coping strategies were effective; the gender of the patient aggressors; and some basic staff demographic information, including gender; age; years of experience; and educational qualifications. It was designed to be completed quickly, as the staff had limited time available. Therefore, the questions were mainly closed-ended or tick boxes were employed.

PROCEDURE

Prior to commencement of the study, ethical approval was obtained from the Princess Alexandra Hospital (HREC 2005/112) and Griffith University (CSR/04/05/HREC). Staff were then invited to attend one of four information sessions held in their wards to brief them regarding the study. Staff who wanted to participate were given the opportunity in session to complete a questionnaire, which took five to 10 min. Spare copies of the questionnaires were located in the staff room for any staff who did not attend the information sessions to complete later. Staff were instructed that once completed, the forms were to be deposited into the locked box located in their staff room.

RESULTS

DATA ANALYSES

The data was analysed using SPSS (Version 14.0, SPSS Incorporated, 2005). Descriptive statistics were used to summarise demographics and the proportion of the study participants who endorsed items on the questionnaire. Correlation coefficients (Pearson's, point-biserial, and phi) were used to examine relationships between specific item variables, depending on appropriateness of level of measurement (Minium, King, & Bear, 1993). An alpha level of 0.05 was used for all statistical tests.

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