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Examining the characteristics of workplace violence in one non-tertiary hospital

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Abstract

Aim.   This study sought to determine the prevalence and characteristics of workplace violence directed at a volunteer sample of nurses at one non-tertiary hospital. Respondents' reasons for not reporting these incidents were also investigated.

Background.   Incidents of workplace violence are increasing worldwide. However, no studies have investigated this phenomenon from the perspective of nurses in Western Australian non-tertiary hospitals.

Design.   Survey.

Method.   A survey was distributed to all 332 nurses working in several areas of one non-tertiary hospital in Western Australia to determine their experiences of workplace violence over a 12 month period.

Findings.   Of the 113 nurses who agreed to participate in this study, 75% reported experiencing workplace violence in the previous twelve months. When asked about their most recent incident, 50% of the nurses said they had reported it verbally, mostly to more senior staff. Only 16% of the nurses completed an official incident report. Reasons for not reporting included the view that WPV is just part of the job and the perception that management would not be responsive.

Conclusion.   This study showed that for this sample of nurses violent events are occurring at a rate that is similar to those reported in other studies. This finding should be of great concern to the organisation and the community in general.

Relevance to clinical practice.   Organisations are obliged to improve the safety of the workplace environment for both staff and patients. The findings of our study may be of help to healthcare institutions in developing education programmes for nurses, patients and their friends and relatives to reduce the impact and frequency of workplace violence.

Introduction and background

There is a consensus in the international literature that workplace violence (WPV) directed at nurses is increasing and that nursing is one of the professions most 'at risk' (Di Martino 2002, May & Grubbs 2002, Hegney *et al.* 2003). Although WPV occurs in all areas of the hospital (O'Connell *et al.* 2000), two settings have been identified as particularly prone to these events, namely emergency departments (ED) (Lyneham 2000, Ergun & Karadakovan 2005) and mental health units (Lanza *et al.* 2006, Maguire & Ryan 2007).

For these two settings, one cause of risk may be the policy shift to a community-based approach to mental health care and a reduction in mental health beds (Australian Health Ministers 1992, Saunders 1997). This move has resulted in a rise in the threshold for patients being admitted to general hospitals with more severe exacerbation of their mental illness (Foster *et al.* 2007). Patients who are mentally ill quite often experience mood disturbances and display sudden, unexpected and ostensibly irrational behaviours which can be a threat to staff. Such behaviours may elicit reactions from staff that, in turn, may lead to an increase in aggression from patients (Bowers *et al.* 2006,Merecz *et al.* 2006).

Mainstreaming of psychiatric patients into the general hospital system has resulted in the ED becoming the main hospital entry point for patients presenting with a mental illness (Wynaden *et al.* 2003, McDonough *et al.* 2004, Kerrison & Chapman 2007). Emergency nurses around the world are reporting an increased level of physical and verbal violence occurring in their departments (Crilly *et al.* 2004, Ergun & Karadakovan 2005). The occurrence of violence in Australian ED's is similar to that found in other countries. For

example, Lyneham (2000)found that ED nurses working in New South Wales (NSW) reported experiencing verbal abuse, threats and assault as part of their daily work. In another Australian study conducted in ED by Luck *et al.* (2007a), a mixed method case study design was used to identify those behaviours exhibited by patients and their family and friends that indicated a potential for them to become violent. These researchers identified five distinctive observable behaviours that indicated such a potential and developed a violence assessment framework based on these findings.

In addition to ED's, the prevalence of WPV on general wards has been investigated (O'Connell *et al.* 2000, Department of Human Services 2005), with the risk being shown to be similar to that in ED and mental health areas (Department of Human Services 2005). For example, in an Australian study conducted for the Department of Human Services (2005) the researchers found that out of the 2662 incidents of WPV reported, 53·6% occurred in ED, 12·1% in the mental health settings and 30% on the general wards. Other Australian studies have demonstrated that nurses working in general hospital settings are at risk of WPV (Hegney *et al.* 2003). For example, O'Connell *et al.* (2000) found that 95% of nurses in their study had experienced verbal aggression and 80% reported that they had been physically assaulted in the past 12 months. Lam (2002) found that 62·1% of nurses working in four major teaching hospitals in NSW had been exposed to violence and aggression at least once and 40% had frequent exposure to WPV in the four weeks prior to the survey.

The risk of WPV in the general wards in the United Kingdom (UK) is also high. Whittington *et al.* (1996) examined the prevalence of violence in the English general hospital setting and found that 90% of reported incidents of WPV occurred in areas other

than the ED, with a high rate of violence and aggression in the general setting. Similarly, Winstanley and Whittington (2004) found that all forms of WPV were widespread and that of all the health care workers surveyed, nurses reported the highest levels of incidents. However, the sample in Winstanley and Whittington's study consisted of several groups of health workers (doctors, nurses, physiotherapists, radiographers and occupational therapists) and as a result the findings could be either under or over-representative since not all professional groups may be equally at risk of aggression. In an attempt to provide a more accurate representation of violence and aggression in the workplace the current study focused on one group of professional health care workers (nurses) across a range of areas but in a single setting – a non-tertiary hospital.

There are several weaknesses in the studies to date. Differences in sample population, survey instruments and the time-frames for recalling incidents of WPV (last three months, last 12 months and four weeks) make it difficult to compare the findings of these studies. In addition, O'Connell *et al.*'s study excluded nurses working in the ED and the mental health unit of the hospital from their sample and Lam did not collect demographic data on the localities where his respondents were working. Further, Luck *et al.*'s (2007a) study investigated WPV only in the ED. As a result none of these studies has provided a comprehensive coverage of the issues of WPV across a range of areas in a non-tertiary hospital setting.

This current study sought to build on previous studies by investigating WPV in a sample of non-tertiary hospital nurses, including those working in the ED and mental health unit, in order to compare findings amongst different settings at a single location. Although WPV has

been examined in (O'Connell *et al.* 2000) and across tertiary hospital sites (Lam 2002) there

is a paucity of literature on this phenomenon in non-tertiary settings. Some of the factors that

differentiate tertiary and non-tertiary designations (for example, non-tertiary hospitals usually

having fewer beds) may have an effect on nurses' experiences of WPV.

A unique factor of the study site, that may have an effect on the prevalence and

characteristics of WPV in the hospital, is that it is the only (387-bed) public and private

facility which is fully owned and operated by a private organisation. The public/private

nature of the hospital is important because the literature has shown that nurses working in the

public sector have a higher incidence of WPV than those working in private hospitals

(Hegney *et al.* 2003, Farrell *et al.* 2006). Of the public nurses in Hegney *et al.*'s (2003) study

in Eastern Australia 47% had experienced WPV in the previous three months as opposed to

29% in the private sector.

One of the major impacts of WPV is the risk that victims of this abuse may leave the

profession and the workforce (Farrell *et al.* 2006). However, due to the reluctance of nurses

to report episodes of WPV, the actual number of incidents and the impact of these events are

difficult to determine (Ergun & Karadakovan 2005, Chapman & Styles 2006, Kerrison &

Chapman 2007). The reasons for not reporting are many and may include lack of time and

management support and the belief that being attacked is 'just part of the job'

(Grenyer *et al.* 2004). Under-reporting and therefore a lack of evidence of the extent of WPV,

may be one reason why more action is not taken by organisations and governments to try to

prevent incidents. To assist educators and administrators to implement strategies to reduce

the number of these events and to lessen the impact of WPV on the perpetrators and victims,

this research examined nurses' reasons for the reporting or non-reporting. In addition, for the development of effective strategies to manage and control episodes of WPV, it is important to understand the extent to which these acts in the hospital setting occur as well as their main characteristics. Although this study focused on a volunteer sample of nurses working in a non-tertiary hospital, the findings may be applicable to state, national and international health-care systems.

Aims of the study

The aim of this research was to investigate the prevalence and the main characteristics of WPV against a volunteer sample of nurses in a range of settings in one non-tertiary hospital in Western Australia. In order to understand the phenomenon of WPV, possible associations with factors such as area of work, age and years of experience of the staff as well as the types of violence perpetrated were investigated. A further aim was to identify the reasons nurses report or do not report these events.

Method

Design

A case study approach was employed to collect quantitative and qualitative survey data from a volunteer sample of nurses in one Western Australian non-tertiary hospital. This approach allowed different data sources to be used to collect information pertinent to different aspects of the aims from participants in a range of different settings in the hospital. Quantitative data were responses (Yes/No responses or frequencies) to survey questions about nurses'

experiences of WPV in the previous 12 months. Qualitative data were collected in the form of responses to open-ended questions in the survey.

Sample

All 332 nurses working in seven areas of the hospital (ED, restorative, medical, surgical, maternity, paediatric and mental health) in May 2006 were invited to participate in the study. Ethics committee approval was obtained from a university and the hospital. All participating nurses were given an information sheet about the study and gave written informed consent prior to completing the survey.

Instrument

The self-administered survey was developed following a review of relevant literature and input from registered nurse experts to help ensure the validity of the questions. The survey consisted, firstly, of demographic questions relating to age, gender, education qualification, position, years of experience, employment status and area of employment. Secondly, respondents were requested to indicate the number and type of incidents of WPV they had experienced in the previous 12 months. Finally, the respondents were asked about their reporting or non-reporting of WPV. An open-ended question at the end of the survey invited respondents to add anything further they considered to be important relating to violent incidents in the workplace.

The initial instrument was reviewed by 12 nurse research academics to check face validity and modifications were made according to their feedback. Following these changes a pilot study of the instrument was conducted with a convenience sample of nurses working in three tertiary hospitals in Western Australia ($n = 25$) and again modified, taking into account the feedback received from the pilot study. The final survey consisted of 10 demographic questions, 18 open-ended questions and 31 closed questions.

Retrospective audit

A retrospective audit (Jansen *et al.* 2005, Gearing *et al.* 2006) involving a systematic review of 42 security notification forms and standard incident reports submitted by nurses in the hospital between 1 January – 31 December 2005. The purpose of the audit was to collect additional information that might provide a fuller picture of WPV at the hospital as well as being used to compare with the findings from the survey. A further purpose was to identify the situational and interpersonal factors surrounding reported aggressive incidents including where the situation occurred, what happened and what the outcome of the report was. The audit contained only confidential de-identified data and was not linked to any of the nurses participating in the study.

Data analysis

Using the software package spss version 15 (SPSS 15.0 release 2006), descriptive statistics were generated from the quantitative data to summarise the demographic data and the characteristics of reported incidents of violence. Differences in the occurrence and characteristics of violent incidents based on staff characteristics such as age, gender,

educational qualification, experience and work setting were assessed using chi-square tests of independence. Qualitative data were transcribed and analysed following the standards of qualitative data analysis procedures, i.e. coding, categorising and clustering (Speziale-Streubert & Carpenter 2003). Following this procedure the major thrust or intent of the transcripts was conceptualised (Field & Morse 1994).

Results

Demographics

By the end of the data collection period of two months, 113 (34%) of the surveys had been returned. Table 1 presents a summary of the respondents' demographic details. The respondents were mainly female, in their early 40s, had been registered in the profession between six months and 40 years (with a mean of 17·8 years) and mainly worked part-time.

Frequency of WPV

The data showed that 75% of the nurses in this sample had been involved in one or more incidents of WPV over the last 12 months – with a total of 2354 self-reported incidents. Twenty five per cent of the respondents reported that they had experienced WPV weekly, 27% monthly and 25% once very six months and 23% had never experienced such an event. Staff in ED and mental health reported the highest mean number of incidents per staff member (46·43 and 40·39, respectively) followed by those in the medical and restorative areas (19·74 and 13·15, respectively). Surgical and paediatric staff reported an average of 3·73 and 4·00 each and the midwives reported the lowest amount with a mean of 1·67.

Ninety two per cent of the nurses reported experiencing verbal abuse, 69% had been physically threatened and 52% had been physically assaulted in the 12 months prior to the survey. Table 2 shows that, using chi-square tests of independence, no significant differences were found in the occurrence and types of violent incidents amongst groups based on the nurse characteristics of age, gender, educational qualification and years of experience.

However, there were significant differences between assaults across levels of employment. Level 3 senior nurses Nurse Unit Managers (NUM) and Clinical Nurse Specialists (CNS) reported proportionately more physical assaults than other levels, followed by the level 2 Clinical Nurses (CN) and Staff Development Nurses (SDN). The level 1 registered nurses (RN) and Enrolled Nurses (EN) experienced the least assaults. For frequency of occurrence (daily, weekly, monthly) of events, the level 2 nurses reported experiencing more events weekly than any other level and the CNS's and NUM's experienced more episodes of WPV monthly. As shown in Table 3, 29% of the level 1 nurses had experienced 1–5 incidents of WPV, 80% of the level three nurses experienced 6–20 and 33% of the level 2 nurses reported experiencing more than 20 episodes over the previous 12 months.

Nature of WPV

As evident from the results presented in Table 4, the area where the respondent worked influenced the number and type of WPV they experienced. Nurses working in the mental health, medical and ED areas experienced the highest proportions of all forms of WPV, however staff working on the surgical and restorative ward also experienced many incidents. The areas experiencing the lowest proportions were maternal child health areas (maternity

and paediatrics). All staff in ED and mental health and almost all staff on surgical and restorative wards had experienced verbal abuse. Approximately three quarters of the staff in the maternal child health areas reported similar abuse. The highest proportion of reports of physical threats came from the mental health, medical and ED areas followed by surgical, paediatrics and restorative, with the midwives experiencing the least amount. The highest proportion of staff reporting physical assault were in mental health and medical areas followed by ED and restorative staff and then surgical. The smallest proportions of these reports came from maternal and child health areas.

Reporting incidents of WPV

When asked whether they had reported their most recent event of WPV, 50% of the respondents stated they had reported the incident, 25·7% had not and 24·3% did not answer the question. Of the 50% who did report, the most frequent was a verbal report to their immediate manager (29%), other senior nursing staff (14·5%) and/or their friends and colleagues (6%). Again, half of the people who had reported did not indicate who they reported to. Only 16% of nurses stated they had completed an official incident report following the event. As shown in Table 5 the ED nurses in our study are much less likely to report WPV (58%) than their colleagues in other areas (24%).

When asked to give their reasons for not reporting, 30% of all the participants in the study stated that WPV is part of the job and that it happens all the time. In addition, when they did report an event, 50% thought that hospital management failed to act on it. However, 70% of the nurse respondents in this study maintained they would report an incidence of WPV if a

nurse (either themselves or another member of staff) was injured or if there was a chance that they would be either laying charges against the offender or making a claim for workers' compensation.

The retrospective audit showed 42 official incident reports had been completed by nursing staff between January – December 2005. Three reports were generated in the ED, 12 in the mental health unit, seven in restorative care, 15 in medical ward and five in the surgical areas. 7% of the nurses reported having multiple injuries, 21·4% facial head and neck injuries, 32% upper limb, 5·5% lower limb 19·6% chest back and groyne and 3·6% reported no injuries resulting from these episodes of WPV. The action taken by hospital management following the reports was invariably making all staff in the area aware of the incident (95%). No other actions were documented.

Use of weapons

Sixty per cent of the respondents reported that they had never encountered an episode of WPV involving a weapon. However, 3% reported that they had been involved in episodes every week where the offender used a weapon and 36% stated they had encountered someone using a weapon at least twice a year. Weapons included knives (3%), guns (6%) and hospital equipment (32%). The frequency of these events was dependent on the area where the nurse worked. Respondents working in the ED tended to experience such events weekly, mental health nurses monthly and those working on the medical and surgical wards more than twice a year. All areas had experienced hospital equipment being used as weapons, ED and mental

health areas had experienced incidents where a knife was used and some of those nurses working in the ED and on the medical wards had encountered an offender with a gun.

Discussion

This study investigated the perceptions of nurses working in one non-tertiary hospital in Western Australia about their experience of the frequency and nature of WPV. Findings showed that organisational factors such as area where the nurses worked, rather than personal characteristics such as age or educational qualifications, determined the frequency and nature of the episodes of WPV experienced. WPV involving weapons was also dependent on area of work.

Frequency of aggression in different areas of the hospital

The frequency of WPV experienced by this group of nurses was similar to that found in other Australian studies (O'Connell *et al.* 2000, Lam 2002), therefore, our findings suggest that there are minimal differences between tertiary and non-tertiary hospitals in this regard. Further, although research has shown that public experience more WPV than private hospitals (Hegney *et al.* 2003, Farrell *et al.* 2006) our study, conducted in a privately-owned facility (admitting both public and private patients), suggests no difference.

In this study, nurses in ED and mental health areas reported more incidents than their colleagues in other areas. Verbal abuse was the most common type of WPV followed by physical threats and then assaults. Similar to the findings in O'Connell *et al.*'s (2000) study,

the surgical wards reported a high proportion of verbal abuse. Winstanley and Whittington (2004) found that staff working on medical wards experienced the most aggression (40%), followed by the surgical ward (36%) and ED (30·8%). Winstanley and Whittington (2004) postulate that the high levels of aggression experienced by the medical ward nurses could be related to events involving patients on the ward for older people which was included in the medical ward statistics. For the purpose of the current study the restorative (aged care unit) was investigated separately from the medical/surgical wards, with both medical and restorative reporting high rates of incidents. Compared with ED, surgical and mental health wards, the rate of all types of WPV on the restorative ward was higher than those found in O'Connell*et al.*'s (2000) study, where 45·8% of nurses working on the geriatric ward experienced verbal aggression on a monthly basis. The difference in the findings between our and O'Connell *et al.*'s studies could be related to the non-tertiary status of the case study hospital as opposed to the tertiary public setting in O'Connell *et al.*'s research.

The mental health nurses in this current study also reported experiencing verbal (100%), physical threat (100%) and assault (84·6%). These findings are similar to those in other Australian studies. For example, 84·3% of the psychiatric/mental health nurses in the Farrell*et al.* (2006) Tasmanian study had experienced verbal or physical abuse during the previous four weeks. In another Australian study,Daffern (2007) found that 62% of mental health nurses in their study had experienced verbal aggression and 29·1% physical aggression in the six months under review. Our study has shown mental health nurses' experiences of physical assault to be much higher than those in Daffern *et al.*'s study. These differences may be due to different treatment options or organisational policies when dealing with violent patients.

Nurses working in maternity and paediatric wards reported the lowest amounts of all forms of WPV. The abuse they received tended to be verbal rather than physical, however, 26·7% of the midwives and 20% of the paediatric nurses had been physically assaulted in the same time period. These findings differ from those found in Winstanley and Whittington's (2004) study where 12% of the staff working in maternal and child health areas reported verbal aggression from patients and their visitors in the previous year. In our research there was little difference between the behaviours directed at staff from patients or from visitors, whereas in Winstanley and Whittington's (2004) study, visitors were the main offenders. In their study visitor aggression was highest in ED and the women and children areas. Winstanley and Whittington postulate that this phenomenon arises because children, female partners and those that are critically ill are more vulnerable and their visitors are, therefore, more protective of them. This difference between the two studies can be explained by the fact that in areas such as maternity, mothers as patients are also protective and therefore may become violent.

Use of weapons

Work area also determined the type and use of weapons during an event. All areas had experienced hospital equipment such as intravenous (IV) poles, glasses, chairs, needles and syringes and patient files being used as weapons. Some areas of the hospital were more prone to violence using more dangerous weapons. For example, the ED and mental health areas had experienced incidents where a knife was used and those nurses working in the ED and on medical wards had encountered an offender with a gun. It may be that those patients carrying weapons were armed for other purposes and had not necessarily planned to use them against

nursing staff, however to ensure staff safety it is timely for organisations to consider the introduction of metal detectors on all entry points into the hospital.

Similarly, ED nurses in Lyneham's (2000) study expressed concerns regarding an increase in the use of weapons such as guns, knives, needles and syringes. Cembrowicz. and Shepherd (1992) reported that the physical injuries sustained by nurses in their study resulted from such things as furniture and fittings (the most common), knives, wheelchairs, broken bottles and glass, scissors, needles and syringes. Furthermore, 20% of the ED nurses in Dean's (2004) study had been hit with an object in the last year. If organisations provide properly secured areas where hospital equipment can be stored, this could reduce the opportunity for offenders to access these apparently readily available weapons.

Reporting and non-reporting of WPV

Only 16% of the 2354 incidents of WPV in this current research were formally reported. The non-reporting of violent acts is well documented in the literature (Ergun & Karadakovan 2005, Chapman & Styles 2006). Researchers have found that formal reports are written only 8–12% of the time (Mayhew & Chappell 2003). One of the reasons that nurses in our study gave for not reporting is that they considered WPV is part of the job. Because these events happen all the time and are expected, many nurses thought they were not noteworthy. These findings support those of other studies where nurses were shown not to report because they consider that being a recipient of a violent act is normal and accepted as part of the nature of their job (Cameron 1998, Jones & Lyneham 2000, Di Martino 2002,Grenyer *et al.* 2004).

ED nurses in Luck *et al.*'s (2007b) mixed methods case study did not report that WPV was part of the job; instead they ascribed meaning to their experiences of these events. These meanings or judgements were based on three factors: perceived personalisation of the event, the existence of mitigating factors and the reason the perpetrator presented to the ED. The authors conclude that these factors may be the reasons that nurses in their study did not report any of the 16 episodes of WPV observed during their data collection period. The survey design aspect of our research may have limited the opportunity for our participants to extensively document their reason for reporting or not reporting WPV. Therefore, in order to enable clinicians, educators and administrators to develop policies to prevent WPV it is important that future research focus on the reasons nurses do not report these events.

Another reason nurses in our study gave for not reporting WPV is they considered that when they did report an event hospital management failed to act on it. Other studies have similarly shown a perceived lack of support from administrators following an episode of WPV (May & Grubbs 2002, Henderson 2003, Dean 2004). Nurses in Lyneham's (2000) study stated that administration were punitive and blamed the staff for causing episodes of WPV. To develop effective strategies to deal with violence the number of nurses reporting these events needs to increase. We argue that organisations are obliged to provide nurse victims of WPV with the necessary support, education, encouragement and time to complete official reports. In addition, if administrators and governments are serious in their intention to reduce WPV and provide staff with safe work environments, they should be seen to act on all reported WPV. Those nurses that report episodes of WPV should receive positive feedback from all levels of nursing management.

Limitations

There are several limitations to be considered when interpreting the findings of this study. One of the major limitations is the use of a sample of volunteers which itself threatens external validity. This form of sampling gave the researchers little control over the respondents and therefore limits the generalisability of the findings, as does the fact that the study was conducted in just one non-tertiary hospital. Again, the return rate of 34% is low and may have compromised the reliability of the data (Cohen *et al.* 2007). However, according to Burns and Grove (1987) the response rate to mailed questionnaires is usually between 25–30%, so the rate in this case is slightly better than is usually expected. All efforts were made by the researchers to achieve as good a response rate as possible. It may be that those nurses who failed to return the questionnaire had not experienced any episodes of WPV and thus considered they had little to offer the study. Others may have considered they were too busy to participate. In addition, even though anonymity was assured, some of the nurses invited to participate may have been reluctant to share their experiences of WPV. Therefore, the rate of WPV identified in this study may not be an accurate picture of these events. However, as the prevalence rates of violence and aggression in this current research are similar to those in found in other Australian studies (O'Connell *et al.* 2000, Lam 2002, Department of Human Services 2005) the findings support the view that WPV is a regular occurrence for this group of nurses.

Conclusion

This study determined that nurses working in all areas of one non-tertiary hospital in Western Australia are experiencing all forms of WPV. However, nurses working in mental health, medical and the ED reported higher levels of verbal and physical abuse than their colleagues

in other areas of the hospital. In contrast, nurses working in the maternity and paediatric wards are experiencing much lower levels of these incidents. To gain a deeper understanding of the prevalence and nature of WPV in non-tertiary hospitals and to offer empirical validation of our survey instrument we suggest that further research be conducted in other non-tertiary settings.

The nurses in this study were reluctant to report episodes of WPV unless they considered the event to be serious, a finding supported by the retrospective audit of the hospital's formal incident reports. The audit showed that 96% of the reporting nurses had received one or more injuries as a result of an episode of WPV. To increase the incidence of reporting, subsequent research should be conducted to gain an understanding of nurses' decision making processes in reporting or not reporting events. In addition, to provide clinicians, managers, educators and administrators with an understanding of how nurses cope with WPV, future studies should be conducted to investigate how individuals adapt to violent episodes.

Relevance to clinical practise

The findings of our study provide educators and administrators with indicators to help them develop education programmes aimed at nurses, patients and their friends and relatives. Programmes need to take into consideration ward settings, attacks using weapons, reporting incidents of WPV and strategies to ensure safe work environments. In this way organisations can fulfil their obligation to provide both staff and patients with more secure milieu in which to relate and interact.

Contributions

Study design: RC, IS; data collection and analysis: RC, IS and manuscript preparation: RC, IS, LP, SC.

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Table 1.   Demographic characteristics of nurse respondents

Nurse demographics	Percentages of total sample (%)
Gender	
Female	92
Male	8
Level	
Registered nurse	52·2
Clinical nurse	19·5
Clinical nurse specialist	3·5
Nurse unit manager	5·3
Staff development nurse	2·7
Enrolled nurse	7·1
Unknown	9·7
Work areas	
ED	23
MH	11·5
Maternity	13·3
Medical	10·6
Surgical	19·5
Restorative	11·5
Paediatrics	4·4
Unknown	6·2
Educational level	
Hospital based diploma	41·6
Bachelor degree	33·7
Post graduate degree	10·7
Unknown	14
Employment status	
Full time	31
Part time	62·8
Unknown	6·2
Average years of experience 17·8 years (SD 9·50)	
Average age 42·7 years (SD 8·35)	

Table 2. Occurrence and types of violent incidents amongst groups based on the nurse characteristics of age, gender, educational qualification and years of experience

Group	No/rate	Type	χ^2	df	p
Age		Verbal abuse	0·07	1	0·79
		Physical threatassaults	0·15	1	0·70
			0·07	1	0·79
	Rate		1·27	4	0·87
	Number incidents		1·37	4	0·85
Level of employment		Verbal abuse	0·72	2	0·69
		Physical threatsassaults	4·23	2	0·12
			7·50	2	0·02*
	Rate		15·21	6	0·02*
	Number incidents		18·79	6	0·005**
Gender		Verbal abuse	0·58	1	0·45
		Physical threatsassaults	3·16	1	0·08
			0·05	1	0·83
	Rate		1·28	4	0·86
	Number incidents		12·66	26	0·99
Education level		Verbal abuse	12·26	10	0·27
		Physical threatsassaults	10·12	10	0·43
			12·58	10	0·25
	Rate		37·40	40	0·59
	Number incidents		218·72	260	0·97
Years of experience		Verbal abuse	0·59	2	0·74
		Physical threatsassaults	0·48	2	0·79
			2·71	2	0·25
	Rate		11·21	8	0·19
	Number incidents		1·18	4	0·89

*$p < 0.05$, **$p < 0.01$ using chi-square test of independence.

Table 3. Incidents, rates and types if WPV by age, gender level of employment, years of experience and educational level

	Number of incidents			
	0%	1–5%	6–20%	>20%
Level				
1 (RN/EN)	26·2	29·2	21·5	23·1
2 (CN/SDN)	8·3	16·7	41·7	33·3
3 (CNS/NUM)	10·0	10·0	80·0	0

$\chi^2 = 18\cdot80$; df = 6; $p = 0\cdot005$

Table 4. Types of WPV by area of work

Area of work	N	Verbal % (n)	Physical threat % (n)	Physical assault % (n)
ED	26	100·0 (26)	76·9 (20)	50·0 (13)
Surgical	22	90·9 (20)	63·6 (14)	40·9 (9)
Maternity	15	73·3 (11)	26·7 (4)	26·7 (13)
Mental health	13	100·0 (13)	100·0 (13)	84·6 (11)
Restorative	13	84·6 (11)	53·8 (7)	61·5 (8)
Medical	12	100·0 (12)	91·7 (11)	75·0 (9)
Paediatrics	5	80·0 (4)	60·0 (3)	20·0 (1)
Other	6	100·0 (6)	83·3 (5)	50·0 (3)
Total	112	(103)	(77)	(58)
χ^2		13·97	24·40	15·59
df		7	7	7
p		0·05*	0·001**	0·03*

$*p < 0.05, **p < 0.01.$

Table 5. Reporting practises by work area

	Report	
Work area	Yes	No
ED	42%	58%
Other areas	76%	24%
χ^2 value 9·023	df 1	$p = 0\cdot003$

*$p < 0\cdot05$.