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VIOLENCE TOWARDS REMOTE AREA NURSES: A DELPHI STUDY TO DEVELOP A RISK MANAGEMENT APPROACH

by

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Abstract

Incidents of occupational violence against nurses are unacceptably high. Remote Area Nurses in Australia frequently encounter violence in the work place and have limited resources to deal with the problem. Adopting a risk management approach, and utilising the Delphi method, a panel of expert Remote Area Nurses (*n*=10) from geographically diverse communities, identified and prioritised hazards that increase the risk of violence and made suggestions for controlling those hazards.

Priority hazards included; building maintenance and design, attending call-outs away from the clinic, staff inexperience and lack of knowledge about the community, as well as intoxicated clients, communication difficulties and a work culture that accepts verbal abuse as “part of the job”. Orientation, education and support of staff were identified as strategies to improve the personal safety of Remote Area Nurses, along with staff involvement in the development of policies and procedures. Collaboration between the community and health service to address the broader issues of violence within the community and towards health service staff was identified as an essential strategy in reducing the risk of violence.

A ‘toolbox’ of strategies is suggested in recognition of the complex nature of occupational violence within the remote health context. Further development and assessment of these tools could decrease the incidence of violence amongst remote health professionals in Australia and overseas.

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Chapter 1: Introduction

Background to the study

Remote Area Nurses (RANs) work in the most geographically isolated parts of Australia. RANs are often the sole resident providers of health care in the region and either individually or in small groups; often with Aboriginal Health Workers, they are responsible for the total health care for that community . "*Remote Area*" can be defined according to geographical areas classified as 'remote' or 'very remote' by the Australian Bureau of Statistics (2003). The Australian Standard Geographical Classification (ASCG) categorisation is based on road distance to services, and is related to the geographical location of most Remote Area Nurses (Wakerman, 2004). The figure below graphically displays the vast area of Australia classified as "very remote" in white, and "remote" in pale grey.

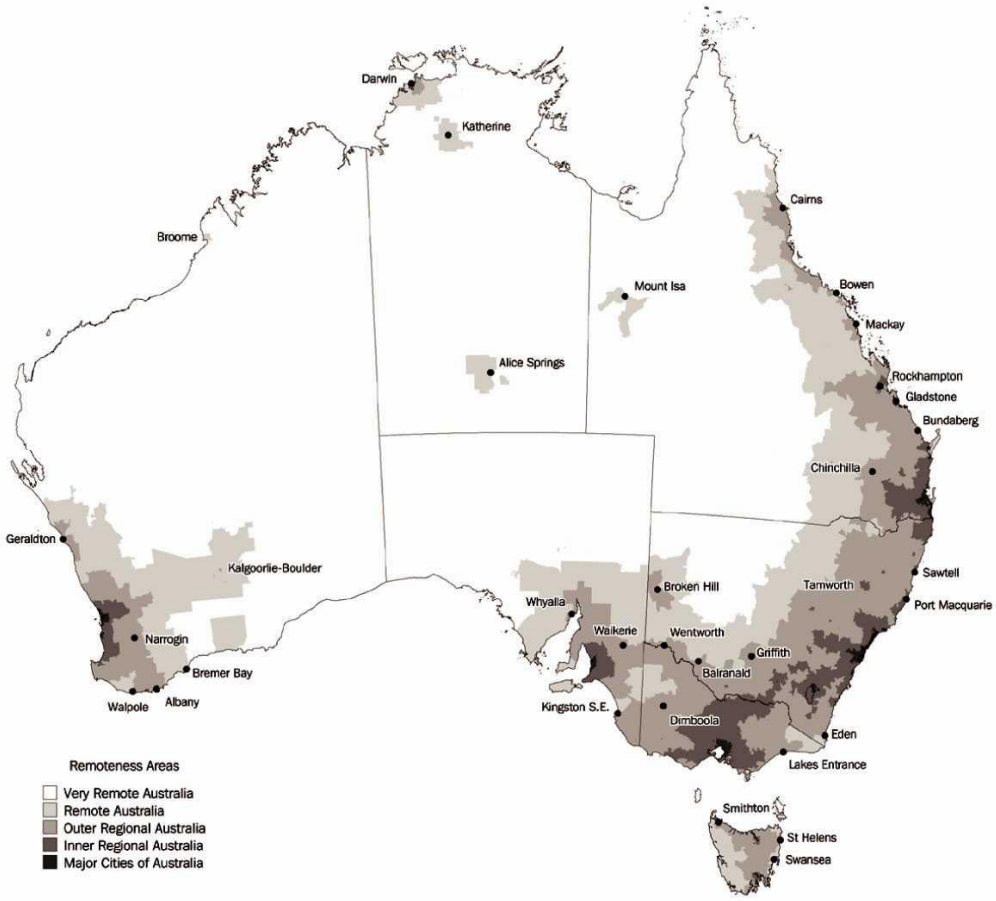

Figure 1 ASCG categorisation of remoteness areas (Australian Bureau of Statistics, 2003)

The largely indigenous communities RANs serve (Lenthall et al., 2011) are typically the most socially disadvantaged and 'health poor' people in Australia (Cramer, 2006; Dowd & Johnson, 1995; Smith, 2007). RANs are mostly women (Lenthall, et al., 2011), often work alone and are almost universally required to provide after hours medical assistance (Ellis & Kelly, 2005; Fisher et al., 1996). The Council of Remote Area Nurses of Australia (CRANA*plus*) has described the role of RANs as follows:

> RANs in Australia provide and coordinate a diverse range of health care services for remote, disadvantaged or isolated populations. Their practice is guided by primary health care principles and includes emergency services, clinical care, health promotion and public health services. RANs work in a variety of settings including outback and isolated towns, islands, tourism settings, railway, mining, pastoral and Indigenous communities(2003p.107).

There are a variety of locations for RAN practice (Cramer, 2005). This practice is not limited to the clinic buildings but often covers vast geographical areas of wilderness as well as many isolated outstation communities that may house only one or two families. RANs are frequently called to private homes, the public bar or community buildings to attend to emergencies or situations where the patient cannot physically get to the clinic. The absence of ambulance services in most communities means the RAN takes on the patient transport role as well. There are also instances where the RAN is required to attend to patients in Police custody. Occasionally, there are times where patients come for treatment directly to the RANs private residence which is often provided by the employer (Cramer, 2005; Currie, 2007). However, this practice is prohibited for Northern Territory Government employees (Northern Territory Government, 2006).

The scope of practice and variety of location of practice, creates situations of increased risk of violence unique to Remote Area Nursing (Cramer, 2006). This risk is greatly enhanced by the solitary nature of the work and lack of resources within the community to call on for support (Lenthall et al., 2009). Ferns, Cork and Rew (2005), claim that staff who are highly stressed and under-resourced are more likely to be the victims of violent incidents due to longer patient waiting times and a potential to project their stress onto clients. Staff turnover is also typically very high (Cramer, 2006; Rickard, 2010) with the most common length of service in remote areas at just two months (Rickard, 2010). This high level of staff turnover, is related to the difficulties inherent with staff shortage, physical/emotional exhaustion of being 'everything to everyone', working outside of legal/ethical boundaries and lacking the support needed to maintain personal safety (Cramer, 2005; Dowd & Johnson, 1995; Ferns, et al., 2005; Lenthall, et al., 2009). Violence in the workplace has been cited as a significant factor in staff turnover (Jackson, Clare, & Mannix, 2002; Lenthall, et al., 2009).

Incidence and effects of violence

A study aiming to identify the job characteristics that carry an increase in violence found that many aspects of RAN practice have a positive correlation to workplace violence from the public. These characteristics included; physical and emotional care of others, denial of service, working alone, making decisions that affect others, dispensing drugs, going to a client's home, interacting with clients who are frustrated or under the influence of alcohol/drugs and medication. These characteristics placed nursing top of the list of high risk jobs in their study, above police and security guards (LeBlanc & Kelloway, 2002). Holmes (2006,p.221), argues that violence is an unavoidable aspect of nursing practice and that "nurses should have everything they need in order to continue providing treatment, even though the patient becomes violent". Despite this, the true extent of violence against nurses is unknown due to significant under-reporting of violent incidents (Ferns, 2006; Fisher, et al., 1996; Luck, Jackson, & Usher, 2006). A study by Fisher et al. (1996,p.190), indicated that RANs are "living with frequent threats to their personal safety while on duty, on call and off duty". A recent study by Opie et al. (2010), has revealed a statistically significant increase in the self-reported incidence of violence against RANs over the last 13 years, with 66% reporting concern for their personal safety. Violent incidents include verbal aggression and obscene behaviour, property damage, physical violence, sexual harassment/abuse, telephone threats and stalking (Fisher, et al., 1996).

The consequences of involvement in violent events are difficult to measure but Post Traumatic Stress Disorder (PTSD) has been identified in RANs (Chaplin & Allison, 1998; Jackson, et al., 2002; Lenthall, et al., 2009). The respondents of a study by Fisher described feeling "scared, threatened, worried, uneasy, sleepless, unsupported, stressed, helpless, shocked, and insulted during and after the episode of violence" (1996,p.195). Effects of violence on the employer include decreased productivity, increased sick leave, workers compensation claims, litigation and other costs associated with the recruitment and retention of staff. Property damage and security costs can also be significant (Farrell & Cubit, 2005).

Purpose of the study

The purpose of this study was to develop an understanding of the hazards encountered by RANs that contribute to the incidence of violence in their workplace; to identify priority hazards that require action and to make suggestions for the reduction of those hazards.

Operational definitions

For the purposes of this research *"Violence"* includes experiencing and/or witnessing: verbal aggression and obscene behaviour, property damage, physical violence, sexual harassment/abuse, telephone threats and stalking (Fisher, et al., 1996); but does not include violence from co-workers.

Research questions

There is a need to identify the hazards inherent in remote area nursing. These hazards need to be assessed for both the frequency of their occurrence and for severity of effect. Strategies to reduce the hazards need also be developed. Remote Area Nurses possess these data in relation to their community and practise, and need to be involved in the establishment of a management plan for their health and safety (Cramer, 1994). Collecting and analysing this information from a wide variety of nurses would create a resource that could form a basis for managing the risk of violence in the remote health context. Further research could develop, implement and evaluate resources for usefulness in the remote health setting. Armstrong states "It is to be hoped that through the dissemination of knowledge, that the power to arrest the insidious march of violence in nursing is generated"(2006p.209).

Therefore, the questions addressed in this research project were:

- *What aspects of Remote Area nursing practice carry a risk of violence?*
- *Which hazards present the highest risk of violence in the Remote Health context?*
- *What measures can be implemented to reduce the risk of occupational violence towards RANs?*

Significance of the study

Australian Occupational Health and Safety legislation requires that employers have a responsibility to provide a safe workplace for their employees (Armstrong, 2006; National Health and Medical Research Council, 2002). However, many RANs feel under-prepared to deal with issues of violence and some felt unsupported by their employer after a violent incident occurred (Fisher, 1996). Understanding how to assess, estimate and evaluate risk in a variety of settings is vital to safe practice (Wright, Dixon, & Tompkins, 2003). Doyle and Dolan (2002) have identified that the 'risk' of violence is a continuum that is dynamic in nature and best assessed using a framework or guidelines that promote consistent and objective measurement and maintain the flexibility required to account for patient–specific influences and context. Guidelines should promote transparency and accountability, be based on solid scientific rationale, offer practical solutions and yet encourage the use of professional discretion (Doyle & Dolan, 2002).

Consultation with RANs from across the rural and remote areas of Australia; ensuring as great a regional representation as possible, would generate a pool of knowledge that could identify hazards that put staff at risk of violence, specific to the practice of Remote Area Nursing. The same consultation process could generate and refine ideas for reducing the risk of violence that are appropriate and acceptable to the practice of RANs. These ideas could improve personal safety which in turn may lead to increases in recruitment and retention of remote staff and assist employers in their health and safety obligations. While this study deals specifically with RANs, it is expected that it may be applicable to other remote heath workers, including Aboriginal Health Workers, General Practitioners and administration staff as they share the same environmental conditions and many of the same issues relating to living and working in remote communities.

Organisation of the thesis

This thesis is presented in five chapters. This chapter acts an introduction to the background and purpose of the study. The second chapter reviews the literature and provides a basis for the research project. The third chapter describes the methods used in data collection and analysis. It also discusses ethical considerations relevant to this project. The fourth chapter describes the results of the data collection phase and the final chapter discusses these results, describes possible further research direction and draws conclusions. A reference list, questionnaires and other appendices are found at the end of this thesis.

Chapter 2: Literature review

Key words such as, occupational violence, violence, remote area nursing, general practice, mental health, emergency department, community nursing, personal safety, risk management, hazard identification, risk assessment, control measures; were used to search the databases CINAHL, Google Scholar and MEDLINE. Bibliographies of the selected articles were scanned for further relevant references. Preference was given to papers published within the last ten years to focus on most recent research in the area of occupational violence.

Violence towards RANs has been under-estimated in the literature. Published research about violence towards RANs in Australia is scarce and largely directed to describing violent incidents. In the seminal work regarding violence and RANs, Fisher et al. (1996) used a structured questionnaire which included an open-ended question asking RAN respondents to describe a violent incident that had occurred in the last six months (*n*=237). Four in-depth interviews were also conducted. This study described the types, incidence and severity of violence towards RANs and concluded that most respondents rated the severity of their experience as low. This could be interpreted as an attempt to "reassure themselves and others that they are maintaining control of the situation" (Fisher, et al., 1996,p.196). A reanalysis of Fisher's data (Figure 2) clearly shows the majority of respondents indicated the severity of their experience of violence was 3, 4 or 5. The numerical categorisations were not defined in the paper beyond 1= low severity and 5= high severity. However, if category 3 is considered "moderate", it could be concluded that the severity was most commonly reported as moderate to severe and not low as the author suggests. The Fisher et al. study does not adequately describe why RANs were experiencing violence or identify strategies to improve the personal safety of RANs.

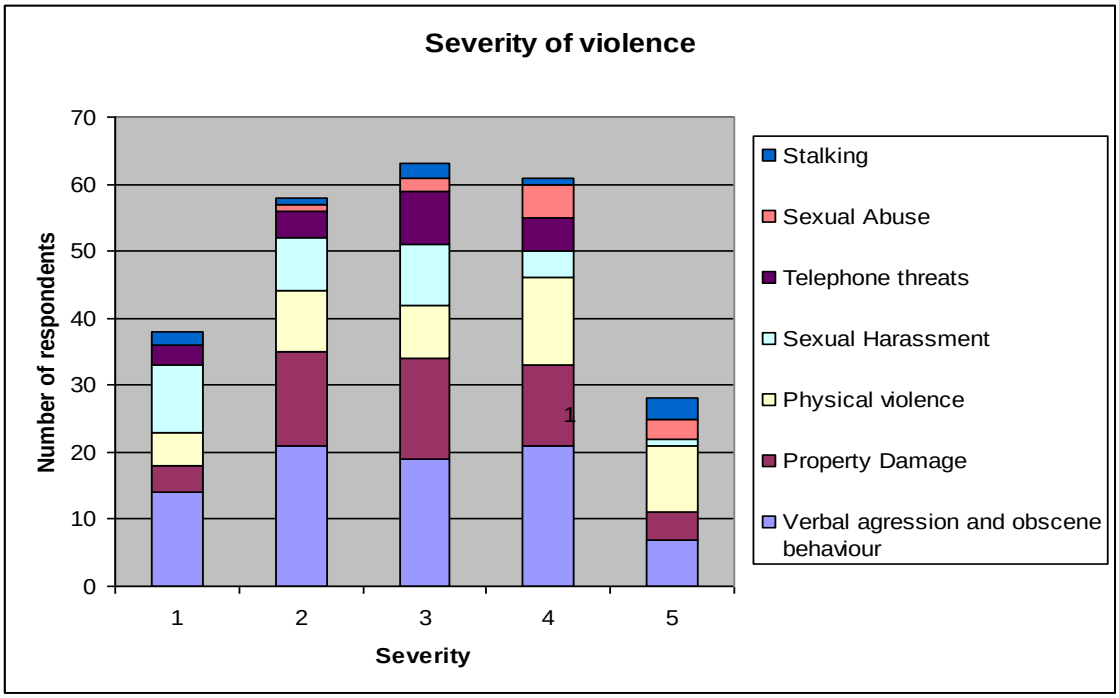

Figure 2 Graphical representation of perceived severity of violent experiences (after Fisher 1996).

A recent cross-sectional study used a structured questionnaire to assess the current incidence of violence and then compared the results to Fisher et al's work (Opie, et al., 2010). A total of 349 nurses working in Very Remote Australia participated in the study. The study concluded that the self-reported incidence of workplace violence had increased significantly over the past 13 years. This apparent increase in violence is concerning and deserves further investigation.

The authors also suggest that RANs experience more occupational violence than nurses in metropolitan areas. This suggestion has some support in the literature (Hegney, Plank, & Parker, 2003; Senate Community Affairs References Committee, 2002), however, some studies of nurses in the acute setting in Australian metropolitan hospitals have described higher rates of occupational violence than RANs (Holden, 1985; O'Connell, Young, Brooks, Hutchings, & Lofthouse, 2000). Despite the lack of empirical data directly comparing the two populations, RANs are unlikely to receive the same level of support as their urban counterparts primarily due to lack of resources.

International research pertaining to remote area nursing comes mainly from Canada which also has nurses working advanced practice roles in areas of geographical isolation and with indigenous peoples with similar levels of poor health as Australia (MacLeod, Browne, & Leipert, 1998). Research pertaining to the context and practice of RANs in Canada is minimal and no studies investigating occupational violence in this group could be found. Results from this current study may be relevant to international audiences.

Risk management approach

A Risk Management Approach which encompasses the overall process of hazard identification, risk assessment, developing control measures, implementation and evaluation, is commonly used as a framework to systematically address the issue of occupational violence (Fisher, et al., 1996; Grammeno, 2009; Northern Territory Government, 2005; WorksafeWA, 2009). A National Health and Medical Research Council (NHMRC) report (2002) was developed as a resource to assist health workers in remote areas to deal with issues of violence in their communities. This substantial document identifies many relevant issues but fails to adequately describe practical measures to address the problem of occupational violence. The report suggested that a risk management approach be implemented to enable systematic review of hazards and risks. This approach requires further exploration of context and development of practical solutions to problems that are identified.

Hazard identification

All employers are required by Australian Law to develop a process of hazard identification. A hazard is something that causes exposure or vulnerability to injury or loss. It may be a work practice, an environmental exposure or a person. Policy and procedures cannot be developed until the hazards have been identified (Grammeno, 2009). Violent incidents within the healthcare sector are characterised by the interplay of four characters: the nurse(s); the client(s); their environment; and the organisation in which the interaction occurs (C. A. Holmes, 2006; Viitasara & Menckel, 2002). Hazard identification requires a rich understanding of all four characters. Observation of the workplace, review of incident reports and consultation with employees are often used to identify hazards and allow practice reviews and improvements to occur (Chaplin & Allison, 1998; Grammeno, 2009; WorksafeWA, 2009). However, as discussed previously, the phenomenon of under-reporting is well established. This under-reporting limits the value of reviewing incident reports to identify hazards as the data will be incomplete. Workplace observations and consultations are a costly and time consuming task particularly in remote areas.

Risk Assessment

Assessing the risk of identified hazards revolves around making judgements as to the likelihood of an event happening and considering the possible consequences of that event (Grammeno, 2009; National Health and Medical Research Council, 2002; WorksafeWA, 2009). These judgements allow individual hazards to be prioritised and control measures implemented based on available budget and resources. For example, the likelihood of a nurse attending a patient experiencing acute psychosis may be

unlikely, however the consequences of being attacked by that person could be *extreme*. This would make the control of this hazard a high priority (National Health and Medical Research Council, 2002).

In order to adequately evaluate the likelihood of violence in any given situation the nurse needs to make judgements based on objective and subjective factors. The development of an assessment tool specifically for use in remote areas could provide a basis for forming judgements regarding the risk posed by violent clients. Likewise, a framework for surveying the surrounding environment could assist RANs in assessing the level of risk posed by a particular situation.

Control measures

There is a need to develop practical measures for nurses who must manage situations of aggression or violence (Wand & Coulson, 2006). Control measures should aim to empower the nurse to limit the duration and extent of the violent incident (Viitasara & Menckel, 2002). Determining appropriate measures to manage the risk of violence must begin with the hazards identified by the risk assessment as being of the highest priority. Wherever possible the hazard needs to be eliminated. This is not always viable so substituting with a lesser hazard, modifying the work system or process and isolating the hazard needs to be considered. If control of the risk is still not achieved then protection of the worker needs to be provided. This may involve physical barriers or personal protective equipment like panic alarms (Grammeno, 2009).

Having policies and procedures in place regarding occupational violence are seen to be an effective strategy to decrease occupational violence (Nachreiner et al., 2005). New staff should be orientated to the organisation's policies and understand personal safety procedures from the very first day in their community (National Health and Medical Research Council, 2002). 'Zero tolerance to violence' policies are commonly cited but these have not been adequately evaluated and confusion exists around the actual implementation of these policies (C. A. Holmes, 2006; Wand & Coulson, 2006).

Studies have shown that training can significantly reduce the incidence of violence towards healthcare workers by teaching them to intervene safely in a crisis, identify and diffuse situations that are escalating towards violence and act proactively to reduce the incidence of violent behaviour (Farrell & Cubit, 2005; Oostrom & van Mierlo, 2008). However, attendance at training courses alone will not necessarily equip staff with all the skills needed to manage aggressive behaviour and frequent refreshers and new resources are needed for adult learning to occur (Farrell & Cubit, 2005). It is unknown if the current training needs of RANs in relation to aggression management are being met.

Most RAN practice is guided by the CARPA standard Treatment Manual (Central Australian Rural Practitioners Association, 2009) and the Clinical Procedures Manual for remote and rural practice (Council Remote Area Nurses Australia, 2009) or in Queensland the Primary Clinical Care Manual (Queensland Health and Royal Flying Doctor Service, 2009). Within the mental health sections of these manuals, is advice regarding personal safety, specifically when assessing or treating patients experiencing acute mental health issues. Although mental illness is often cited as a risk factor for violence, most patients are not violent and few incidents actually occur where mental illness is the only precursor (Doyle & Dolan, 2002). Therefore, assessing the risk of violence and establishing practice that promotes personal safety should occur constantly in all work situations and not just when dealing with the mentally ill.

Summary

Although much has been written about the phenomenon of occupational violence and nursing, the literature specific to RANs in Australia is scarce. The seminal work by Fisher et al. (1996) and follow-up study by Opie et al. (2010) point to an increase in violence towards RANs over the last 13 years. Except for Cramer (2005), little has been written about the context and practice of RANs, especially what makes them vulnerable to violence. Violence is cited as a significant stressor for RANs and is a contributing factor to the frequency of staff turnover in remote areas (Lenthall, et al., 2009).

This study adopts a risk management approach as a commonly used framework for addressing occupational health and safety problems (National Health and Medical Research Council, 2002). When considering the specific problem of violence in a healthcare setting, the role of four main characters; that is, environment, nurse, client and organisation should be explored (Viitasara & Menckel, 2002). Starting with identification of the hazards specific to the practice of RANs, then considering the likelihood and severity of consequences of those hazards, leads to development of ways of reducing the risk of violence; in this case; towards RANs.

Chapter 3: Methods

Introduction

This chapter describes the process that was used to collect and analyse data in this project. Justification for the use of this method is discussed as well as ethical considerations relevant to this research. A mixed methods approach to data collection was adopted in four phases. Consultation with experts in the field of Remote Area Nursing, using the Delphi process, generated data specific to this context. A review of relevant literature generated further data regarding hazard identification and possible control measures that may be relevant to the context of remote area nursing. These two data sets were compared and synthesised. This information was then validated to the remote health context and measured for consensus amongst a panel of experts.

The Delphi technique

The Delphi technique as a research method, aims to structure and distil large amounts of unpublished information. That is, an individual's experience and knowledge of a topic as opposed to established fact (Adler & Ziglio, 1996). This method allows subjective judgement on a collective basis to address the problem (Waltz, Strickland, & Lenz, 2005). The strength of this method in this study was the focus on documenting what RANs had to say about violence in their workplace. Considering this information in light of published literature allowed a broader understanding of the subject. Presenting this information back to the panel allowed an assessment of relevance to the context of remote area nursing and ensured validity in the researchers' analysis of the data (Koch, 2006).

Further benefit to this method is its ease of use and low cost. Postal Delphis are commonly used but can become costly and time consuming due to postage, paper costs and delivery times. Access to the internet is commonplace, even in remote areas, and email based questionnaires using the Delphi technique have been successfully used with RANs before (personal communication: S. Lenthall 09/04/10). Use of the internet enabled access to participants in remote areas for whom meeting face-to-face would be a very costly exercise. Participants were also able to complete the questionnaires at their leisure without the difficulties of organising a mutually satisfactory time and place. E-mail contact between the participants and researcher allowed questions and clarification of responses to occur when needed. Attempts were made to encourage project ownership and loyalty to enhance response rates (Keeney, Hasson, & McKenna, 2006). These included sending individually addressed emails to

participants and not group emails, using a formal but friendly tone and emphasising that the panel members were selected as experts in their field and that their contribution was highly valued.

Other methods for collecting the required data for this study may have included interviews and focus groups. These methods may have generated more data but would also have drastically increased the time taken for analysis which would in turn have limited the number of participants and rounds. Focus groups may have provided the benefit of stimulating ideas amongst the group but may have produced a false consensus due to the influence of peer pressure (Polit & Beck, 2008). Anonymity between experts is a fundamental aspect of a Delphi study as it limits the influence of peer pressure when attempting to reach consensus (Adler & Ziglio, 1996; Waltz, et al., 2005). The Delphi method allows freedom to express opinion without fear of repercussions or loss of face (Adler & Ziglio, 1996; Beretta, 1996).

Data collection and analysis

The steps taken for data collection and analysis are outlined in the figure below and further described in the text that follows.

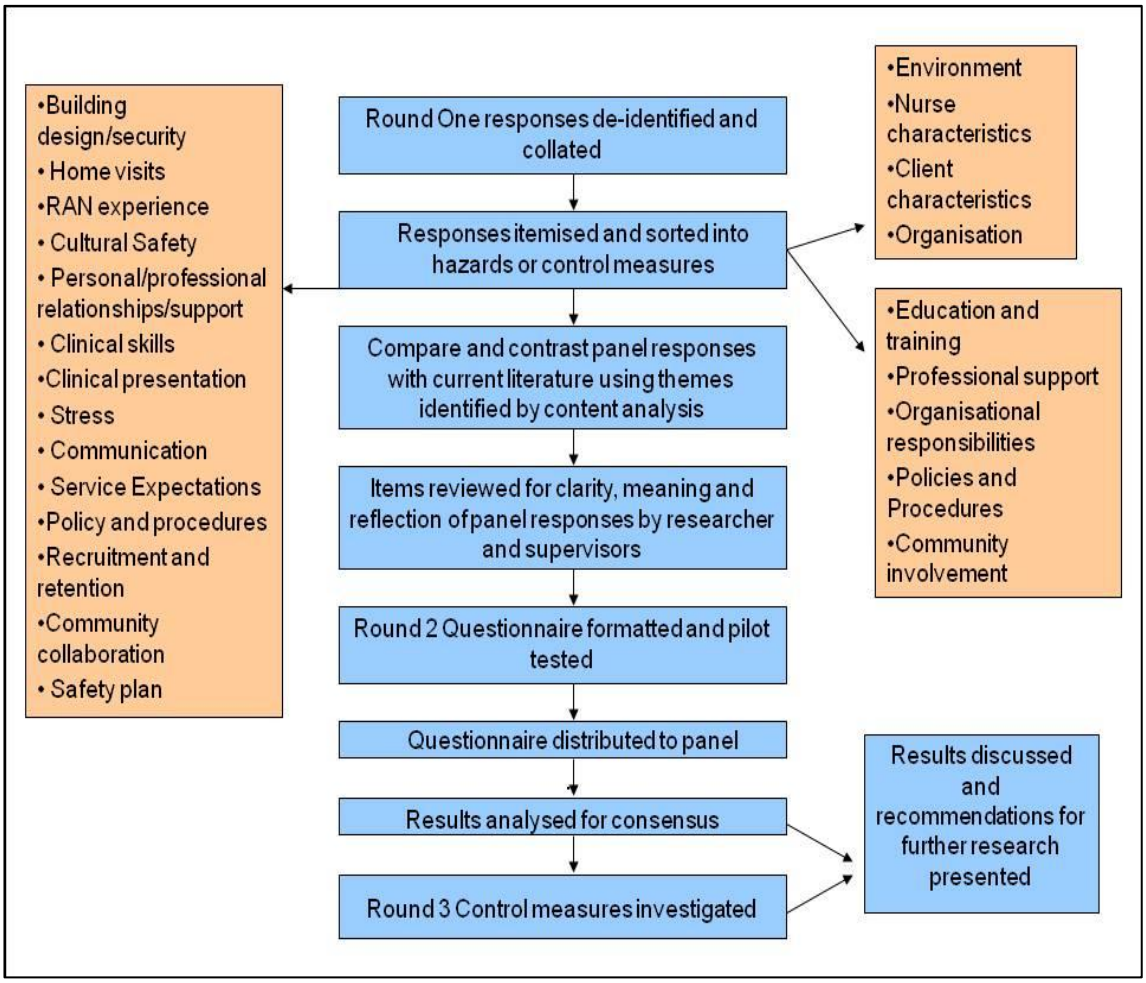

Figure 3 Data collection and analysis

Phase one: Data collection using Expert panel

Safety in the workplace, when seen as a social construct, determines that the culture of the workplace must first be understood in a holistic way and not just by the analysis of objective data such as: incident reports, workers' compensation claims and rates of staff turnover and sick leave. In much the same way "health" is not just the absence of disease, "safety" is not just the absence of violent incidents and consequences (Rochlin, 1999). Therefore, in order to adequately answer the research questions identified in this proposal, qualitative data were collected in the first instance and then assessed for consensus amongst an expert panel according to the Delphi method.

The first round consisted of open-ended questions and took approximately thirty minutes to complete (Appendix D). Each questionnaire was tested in a small pilot study of two participants to test the questionnaire for ambiguity and ease of use (Keeney, Hasson, & McKenna, 2001) prior to distribution to the panel. The pilot study found the first two questionnaires were able to be completed within the specified time frame, however the final questionnaire was considered too arduous and the final section which asked panel members to comment on tools found in the literature was removed. Minor grammatical errors were also identified and changed.

The first and third round required the participants to "reply" to an email sent by the researcher. As the questions were open-ended, this allowed a free flow of ideas without the need to open, save and attach documents. The participants were encouraged to complete the questionnaire within a week of receiving it. Reminders were sent out after two weeks and responses were required within a six week timeframe for each of rounds one and three. One panel member did not manage to complete the first round within the six week period but indicated a desire to remain involved. This participant was involved in rounds two and three.

Data gathered in the first round were collated and grouped according to content analysis process (Polit & Hungler, 1999). Data were initially sorted by the broad themes of nurse, client, environment and organisation. Variables within these themes emerged and these data were synthesized with current literature by conducting a literature search using the themes as search keywords. Relevant information was summarised and then itemised again using content analysis process, before being re-presented to the panel for further consideration and discussion. The frequency of variables was noted by referencing each comment by the code number allocated to each participant (Polit & Hungler, 1999) and this gave an early indication of the priority of each hazard or relevance of particular control measures.

Phase two: Data synthesis with current literature

Content analysis of the open-ended questionnaire collated and grouped the data which allowed the emergence and development of themes (Polit & Hungler, 1999). A literature search was conducted using keywords identified via content analysis described in phase one. Google scholar and CINAHLplus search engines were used to locate papers relevant to these themes. As RAN practice extends beyond that of nursing duties to those usually provided by a range of health practitioners such as, General Practitioners, Pharmacists, Paramedics, Midwives, Social Workers and Mental Health workers (Cramer, 2006; Ellis & Kelly, 2005); these disciplines were included in the search process. This information was summarised, itemised and then reduced in consultation with the research team. These items were included in the second round questionnaire for consideration by the expert panel along with the original items identified by the panel. The total number of items used in the questionnaire was 120.

Phase three: Consideration of data by expert panel

The information collated in phase two, was presented to the expert panel for consideration and comment in itemised form (Appendix E). A Likert scale was used to assess the level of consensus. The questionnaire was in two sections. The first section asked the panel to consider the level of risk each hazard posed to RANs on the scale of: *not a hazard, minor hazard, moderate hazard, major hazard and extreme hazard*. This corresponds with the framework endorsed by the National Health and Medical Research Council (2002). The second section asked the panel to indicate how useful each of the control measures could be to reducing the risk of violence towards RANs. The scale progressed from *not useful* to *useful, very useful* or *essential*. Comment boxes were provided to allow free expression of ideas and comments on the issues raised. Results were analysed using basic descriptive statistics. The mean response was calculated by allocating a numerical value to the above scale and used to prioritise the identified hazards.

The second round questionnaire required significant formatting involving tables to enable the panel members to indicate their choice on a Likert scale. The simplest way to achieve this was to use an online survey tool to write and collect responses to the questionnaire. The tool used was surveymonkey (2010), a free, web tool with high level privacy and security settings. Data was accessible to the researcher only, via a password. An email was sent to the participants that included a link directly to the webpage. The responses were collected by the website and are usually anonymous; however, it was important to keep track of who had completed the questionnaire and to be able to clarify any comments that were left in the comment boxes (Waltz, et al., 2005), so the first question asked the respondents for their name. This also enabled

the pilot responses to be filtered out. The link to the questionnaire remained open until all responses were collected. All participants completed the questionnaire within two weeks, with only one person requiring a reminder email.

Phase four: Discussion and Conclusion

A third round was included to gain a greater understanding of some of the issues that were identified by the panel as being specific to RANs. These issues included how to develop a safety plan; consequences for violent behaviour and how to pass on information about community members with a history of violence. Discussion of the results of phases one to four is presented in chapter five.

Trustworthiness and rigour

The researcher spent considerable time reflecting on her own experiences of violence when working as a RAN and considering the impact that this may have on this research, using a method referred to as 'bracketing' (Polit & Beck, 2008). Self awareness is an essential feature of qualitative research (Koch, 2006), so the researcher documented her experiences with violence when working as a RAN, and considered how these experiences had contributed to her understanding of violence and its effect on RANs. The researcher's notes from the bracketing process (Appendix H) revealed a number of obvious biases which were acknowledged. A conscious effort was made by the researcher to objectively describe and analyse the data to accurately reflect the panels view.

It was decided by the research team, that prior experience as a RAN benefited the study by adding meaning (Koch, 2006; Polit & Beck, 2008), as the context and challenges of this area of nursing practice were understood. This previous experience also increased the professional credibility of the researcher when working with the panel and in presentation of the findings. However, it is possible that the researcher placed greater or lesser emphasis on particular findings or results because of the subjective nature of the data analysis. The potential omission or distortion of the intended meaning of panel comments was minimised by an independent researcher reviewing the original data, analysis and identification of themes. Reference to the code number allocated to each panel member is made in the analysis to allow the thought process of the researcher to be validated. Credibility of the research analysis and findings was also enhanced in the second round with the measurement of consensus amongst the panel acting as a review process (Koch, 2006). Consideration of the panels responses in light of published literature also increased the trustworthiness of the data. This process allowed the panel to review the findings and indicate their agreement. Comment boxes were also included to allow the panel to further clarify any issues they had identified.

Replication of a Delphi study can be problematic. There is no guarantee that the results would be the same if the same information was given to two or more panels (Keeney, et al., 2001). However, this panel was fairly representative of the group being studied so content validity can be assumed (Keeney, et al., 2001). Experts were nominated for the panel by a respected academic in the field of remote health practice. Selection was based on known currency of practice, extended length of practice as a RAN, and involvement in the greater RAN community. This criteria fits with respected nursing theorist Patricia Benners' description of expert nurse in that expert nurses have local and specific knowledge of a particular health service as well as social knowledge and

an understanding of the ‘big picture’ (Benner, Tanner, & Chesla, 2009). Bias in the selection of the panel is evident in that many of the nominated members are known to the researcher and supervisor through their involvement in CRANA*plus*, the Centre for Remote Health and Government agencies. The majority of nominees resided in the Northern Territory and this is also connected to the relationship with the nominator.

Ethical considerations

Data collection and recruitment of participants did not commence until clearance was given by Edith Cowan University, Faculty of Health and Science, Human Ethics sub-committee (Appendix G). No significant harm was anticipated as a result of this research and no notification has been given that the participants or researcher suffered any harm as a result of this research. However, the participants were advised of the Bush Crisis Line 24hour phone counselling number if they felt any emotional distress as a result of participating in this research. The researcher acknowledges that the experts' time is valuable and this project required the completion of multiple questionnaires. Every attempt was made to ensure the questionnaires were not unduly arduous but still met the research aims. Completion of each questionnaire should have taken around 20 to 30 minutes. It is expected that the participants will benefit from the results of this research and have broadened their own knowledge of violence towards RANs. Benefits to the wider community of RANs will occur with publishing of the results of this study in peer reviewed journals and as a result of conference presentation (McCullough, 2010).

The participants were invited to participate by Ms Sue Lenthall, co-supervisor and respected academic in this field, by way of an introduction. The invitation is included as Appendix C. The potential panel members are known to her and may have felt obliged to participate. However, the invite clearly stated that participation was voluntary, and the anonymous nature of the study was reinforced. Participants were asked to contact the researcher directly and as a result, participants were assured that their choice to participate or not, and their contribution was anonymous.

Participants were provided with clear information in regards to the purpose of the study and requirements of the participants before they undertook the questionnaires (Hasson, Keeney, & McKenna, 2000). The information letter is included as Appendix A. Completion and return of the consent form indicated consent (see Appendix B). Participants were advised that they may withdraw from the study at any time without penalty. Anonymity is a vital aspect of a Delphi study. Information that may identify the originator of a comment was removed (Bruce, Langley, & Tjale, 2008).

Only the researcher had access to the identities and e-mail addresses of the participants. These were kept on file on a password protected computer. Participants were issued with a code number for identification purposes only. E-mail contact was via the researcher's ECU student web mail account and group emails (the initial invitation letter) was sent via blind carbon copy method. At the completion of this study, all de-identified questions and correspondence with the panel will be copied to computer disk. This disk will then be stored in a safe place within the School of Nursing, Midwifery and

Postgraduate Medicine at Edith Cowan University for five years. Contact email addresses and other identifying data will be deleted from the researcher's computer at the conclusion of this study.

Summary

The Delphi method provided a framework that enabled the collection and analysis of expert knowledge on the subject of violence towards RANs. Using the internet as a medium for data collection proved successful and provided access to a population scattered across Australia's most remote regions. Assessing consensus amongst a panel of experts checked the validity of data analysis and increased the reliability of findings presented. Confidentiality was maintained throughout the research process and panel members had free, accessible avenues to seek support through the Bush Crisis Line if they suffered any emotional distress as a result of participating in this research.

Chapter 4: Results

This chapter details the data obtained in the course of this study. Demographic data of the panel is presented. This is then followed by results from the first round where panel member's comments have been identified by using their allocated code number. Responses to the second round are displayed graphically then the panel's responses to round three are summarised.

Participant profile

A panel of experts including nurses and other professionals known and respected as experts by their peers; was invited to participate based on the recommendation of Sue Lenthall, co-supervisor and senior lecturer. Regional nurse managers were also invited to participate as it was recognised that they have knowledge of the issues that are reported from their clinics. CRANA*plus* state representatives were invited to participate as elected spokespeople for members of the professional organisation. The combination of recommended experts, RANs and managers from across the remote areas of Australia aimed to minimise bias and ensure heterogeneity of the sample. A total of 34 experts were invited, with 10 participants accepted on the panel. This represents a response rate of 29%. The number of participants in a Delphi study is not prescribed as it is highly dependent on the availability of experts and time and cost of analysis (Beretta, 1996). For a panel of 10, an acceptable level of agreement is 75 to 80% (Bruce, et al., 2008). The first round data was informed by nine panel members, the second round was completed by 10 participants and the final round was completed by five panel members.

Geographical distribution

Using data presented at the annual CRANA*plus* conference (Rickard, 2010), Figure 4**,** shows the geographical distribution of RANs (*n*=1076) by Australian State and Territory. AUS TER refers to Christmas Island and the Keeling islands. For comparison, Figure 5, describes the geographical distribution of the panel members. A single representative from each of Tasmania, Western Australia, South Australia and Queensland, with the balance from the Northern Territory, made up the panel. Although the NT was over-represented on the panel, all of the major regions were represented.

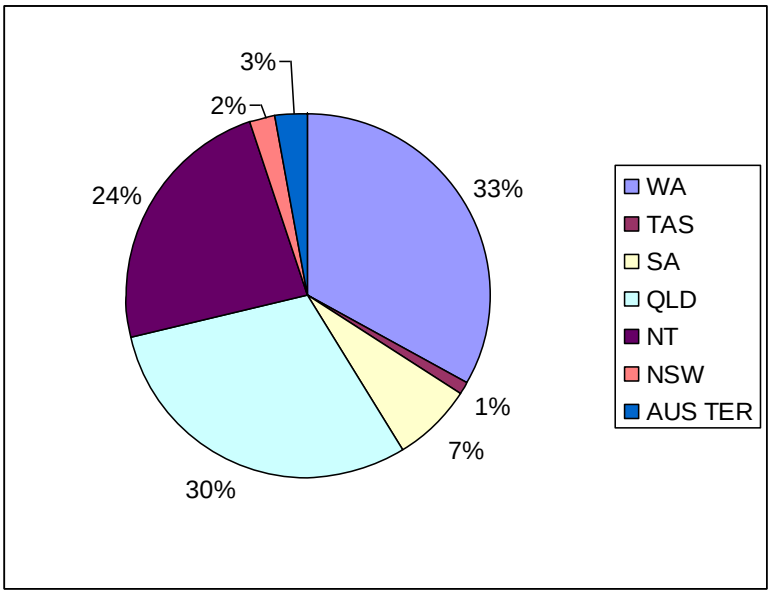

Figure 4 Geographical distribution of RANs across Australia

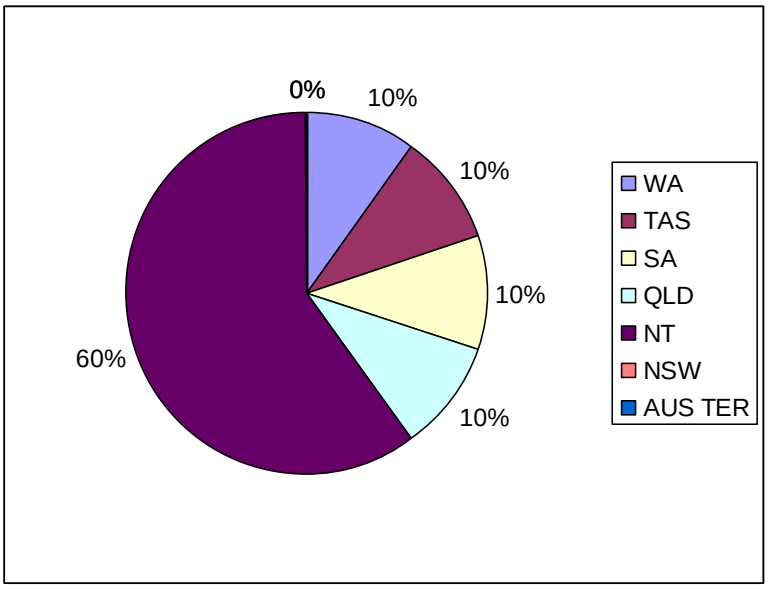

Figure 5 Geographical distribution of Delphi panel

Gender

Eight panel members were female and two were male.

Employment

Eighty percent of panel members indicated that their employer was a Government body and 20% were employed by a Non-government organisation (including Aboriginal Health Service), and 70% are currently employed as a RAN. Of these, three panel members were in communities of less than 500 and three in communities of 500-1500. One panel member worked across eight communities with a total population of 3000. Population of communities employed in as a RAN ranged from 166 to 3000 including those not currently employed as RANs.

Average length of service as a RAN was 13.6 years, with a range of 4 – 25 years. The number of years involved in remote health issues was higher with an average of 16.7 years and a range of four to 30 years. This recognises that some of the panel members have held positions other than as a RAN, for example as a manager or educator. The average length of service of the panel members was significantly higher than that of the overall population of RANs at 3.2 years and a median of 1.5 years (Rickard, 2010).

None of the panel members identified as being of Aboriginal or Torres Strait Islander descent.

Hazard Identification

The panel identified a large number of hazards in the practice of Remote Area Nursing. These items were sorted and classified according to the characteristics of violence, namely: the environment; the nurse; the client; and the organisation (including community) in which the interaction takes place. Items were further grouped according to similar themes that emerged during the analysis process. The code number for each panel member is included in brackets that follow each comment.

Environment

Building design/security

The relative security of the clinic was compromised by poor maintenance and design (08,09,10). Inadequate lighting (02,09,13,), outside obstructions that may conceal a person (09) and lack of control over who entered the premises after hours (02,06,08) which included monitoring the allocation of keys (09) crowd control and bystanders (01,07,09) were identified as hazards. Call buzzers or duress alarms in consulting rooms, staff housing and vehicles (01,09,10), along with a safety plan that detailed who to contact (01,06,09) and access to mobile phones (09) were identified as protective factors. Having a barrier between the person presenting and the nurse was suggested as a method for allowing an initial assessment of the safety of the situation (02,06). A designated safe room (02, 06, 10) and a planned exit strategy from all parts of the clinic (06,08,10) were suggested as vital safety measure for all health centres. Delays by management in attending to issues identified by staff, due to cost and red tape (09), was also identified as a hazard.

A situation common to remote area nursing is the provision of staff accommodation by the employer. Panel members identified that maintenance and security of their residences also played a part in personal safety (02,08); as well as not attending to patients in their own home (10) and having a phone at the clinic to contact the nurse on-call (10).

Home visits

A distinction between consultations in the clinic and consultations in the surrounding community became apparent. Unrestrained dogs (07), and poor street lighting (07) along with going to areas you don’t know (08), were identified as increasing the risk to personal safety for nurses when attending call-outs away from the clinic. Not having access to a vehicle to travel from home to the clinic or call outs after hours was also seen as hazardous (02). The presence of an alcohol outlet in a community seemed to infer a greater risk of violence in that community (01).

Nurse

RAN experience

Panel members provided many comments in regards to the characteristics and skills of the nurse. This suggests that the panel consider this to be a major influence on the incidence and effects of occupational violence. Being single (08) and female (08) appeared to carry greater risk. The nurses' prior experience both with violence (03) and as a RAN was identified (01,02, 03,06,10) as a significant factor in a violent incident. The development of instinctive responses or 'gut feeling" (01,03) and common sense (08,10) was seen as an important skill in assessing risk. A professional and clinically confident appearance was said to "set the tone for the interaction" (02) however another panel member stated that a nurse can be "assertive but perceived as aggressive"(06). The panel identified that highly developed communication skills including de-escalation skills are essential for the RAN (01,08,10). Honesty, respect, listening and referring to others are important characteristics of interactions with clients (08,09). Lack of sufficient skill in the assessment of mental health and behavioural observation was identified as a hazard in remote area nursing practice (02,06,09,10).

Cultural safety

Cultural Safety was frequently noted by the panel as an important skill for RANs. Problems can arise with inappropriate responses to cultural beliefs, and a lack of understanding of family and community structure and hierarchy (01,02,03,06,08,09,10). Several panel members identified that nurses with rigid personal belief systems can fail to adapt to the new culture and expectations of remote area nursing (01,03,08). This could be attributed to lack of preparation, awareness and respect of specific indigenous culture and history of the community (09) as well as understanding of the effects of 'culture shock'. A panel member identified that some nurses have a "personal goal to save" (01) and carry a belief that "Aboriginal people are somehow 'good' and do not have human failings found in all human societies"(01). This attitude was seen to dis-empower clients using the health service. Cultural knowledge seemed to extend beyond that of specific indigenous spiritual, cultural beliefs or customs to more broadly knowing the community (08,10), its history (08), politics (08) and the development of the health service (08). Seeing the health service from the community's point of view and appreciating the power relationships that exist are part of culturally safe practice (08,09). Power imbalance may become a "…potent stimulant for a violent interaction" (08).

Personal/professional relationships/support

Personal and professional relationships were identified as being both supportive but also potentially exclusive to parts of the community. A nurse who forms ‘kinships’ with a particular group, may deny access to health services to other groups (01). Separation of personal and professional relationships was recommended (02). The impact of stress and burnout was described as “missing cues and perhaps being less tolerant”(03) as a result of tiredness and fatigue (03,06,).

Additional comments made by the panel include nurses who are “there for the money” (01) may have an attitude that encourages violence.

Client

Clinical presentation

The clinical presentation of the patient (08) including evidence of alcohol/substance abuse (01,03,08,09,10,13) along with identification of mental health issues (06,08,10) including suicide and depression (10) and history of violence (06,10) was identified as a contributing factor to violent incidents. Petrol sniffing and smoking marijuana were also noted as contributing to violent incidents (10,13).) It was noted that perpetrators of violence were not just men, but women also (13).

Stress

The stress associated with ill health (01,08,09) and social issues (08,09) for both the patient and significant family members was acknowledged by the panel members.

Communication

Differences in language (01,08) including sign or body language (09), health concept and priority with the nurse also contribute to hazardous situations (01,09). There seemed to be a lack of respect towards nurses, particularly by teenage boys (13) and older men (13).

Service expectations

A previous bad experiences with the health service (01) was identified as a contributing to the potential for violence. Specifically noted was the occurrence of a “sudden death/unsuccessful resus [which may evoke]…anger from the community” (09) Denial of service or providing a service different to what the client expects, appeared to be a notable trigger to violent incidents (09,13). One panel member considered that violence towards property is not considered in the same light as violence towards staff due to cultural differences in value of material objects (08)

Organisation

Policy and procedures

Policy and procedures of the employing organisation were recognised as important factors in ensuring personal safety of RANs (02,03,09). Having standards for critical incident management (02) and encouraging the reporting and follow-up of violent incidents was recommended (02,09,10). However, one panel member stated that "policies do more to protect management than staff on the ground" (03) and another stated that "Inflexible, punitive, and pedantic policies and procedures that do not reflect the needs of the community…" can increase the risk of violence (08) by preventing staff from providing the expected treatment. Consultation with RANs in the development of policies and procedures (09,08), community support and evaluation, including assessing compliance to these policies and procedures is seen as a vital aspect of management support (09).

Acknowledgement of the risk and effects of violence and support of measures to reduce the risk were seen as an important role for management (01,02,03,06,13,). Verbal abuse should not be tolerated as "part of the job" (10).

Working alone is a common work practice for RANs. Panel members identified single nurse posts, or posts with less than three staff including nurses, health workers and medical officers (03,07,10) and communities without a police presence as of increased risk (01,03,06,07,08,09). Having a paid 2nd nurse on call or night drivers/escorts were identified as strategies to improve safety (01,10,13). One panel member observed that members of other professional groups, without aggression management skills, may escalate a situation (08). A team approach is vital to creating a safe workplace (10).

Recruitment and retention

Recruitment and retention issues were mentioned by most panel members. High staff turnover exacerbated by short-term contracts (01,06,09,10), inadequate orientation to the community (01,02,03,06,08,09,10) and lack of a mentoring program with experienced staff (01,02,03,06,08) or an AHW (10) were seen as organisational responsibilities that contributed to increased risk of violence for RANs. Honesty about the level of violence in a community was also identified (03,06). Effective selection process when recruiting new staff (08,09) and introduction into the community (08) is seen as essential.

Community collaboration

Collaboration between the health service and the community was identified frequently (01,02,03,06,08,13). Consulting with community leaders, Aboriginal Health Workers and Traditional Healers may aid in developing a mutual understanding of service

expectations (01), orientation of new staff (01), implementation of a safety plan and committee (01,03) and identification of hazards (09). Developing the functional capacity of Aboriginal Health workers was included in the role of RAN's (09). It was noted that nurses were always on-call during times of community stress and disorder (08). Consequences for violent behaviour, including the withdrawal of service should be planned (09) and discussed with the community (01,03,13). A commitment to dealing with the underlying causes of violence within the community should also be evident (06).

Summary

Content analysis of the panels responses to round one, has identified themes as displayed in the following figure.

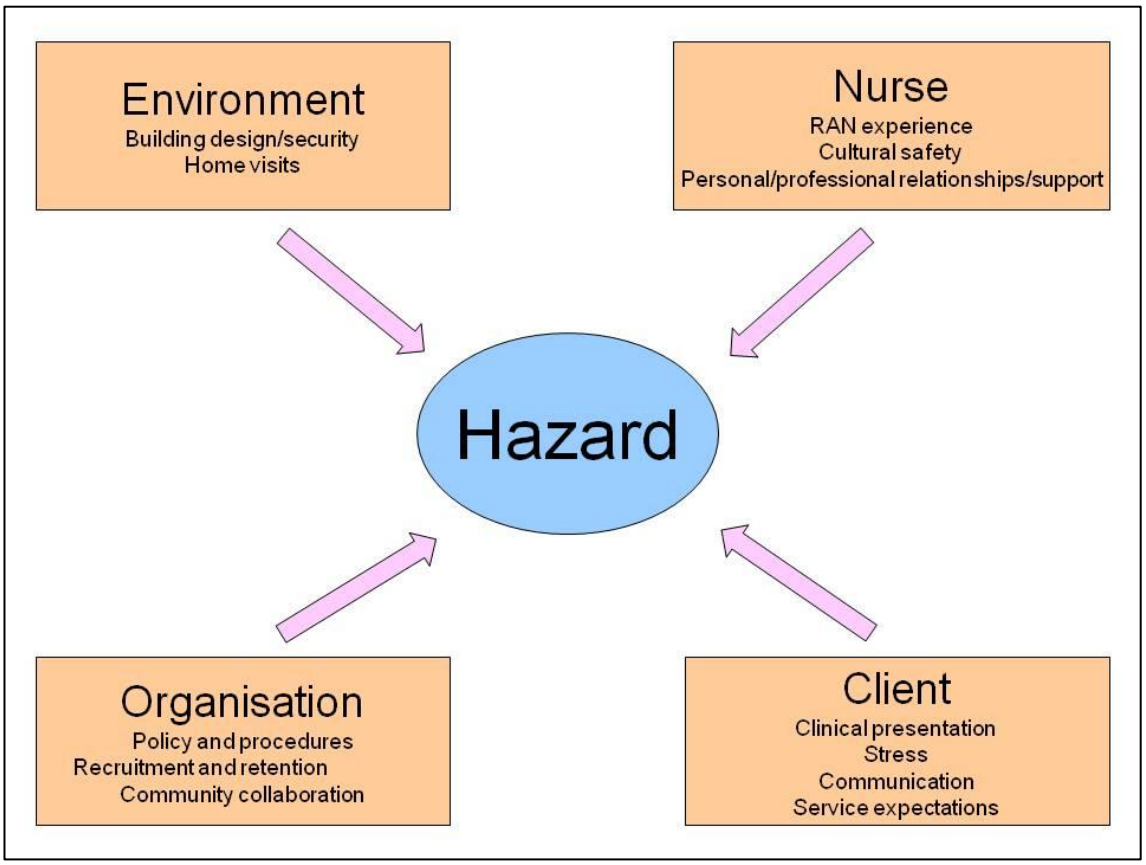

Figure 6 Hazard themes

Control Measures

Many suggestions for improving the personal safety of RANs were provided by the panel and are summarised below (Table 1). The broad themes of *education and training*; *professional support* and *organisational measures* emerged.

Table 1 Aggression management toolbox as suggested by expert panel

Theme	Suggested tool	Tool detail
Education and training	Violence risk assessment	Identification of behavioural precursors to violence.(10,08) Documentation (10)
		Identification of clients with a history of violence. (06,03,10)
	De-escalation techniques/ aggression management skills	Courses/ workshops (06,03,02,07,10,09)
		Including self-defence techniques (07).
	Intoxication care plan	Effect of Alcohol/drugs (03)
		Provide safety for nurse and health care service access for the client (01,10)
		Engaging community support when providing care. (01,)
	Risk Assessment	Assessment of the work environment for hazards. Hazard Identification checklist. (06,02,07,13,01,03,10,08,09)
		Self assessment (10)
		Evaluated for appropriateness and effectiveness (09)
	Mental Health Support	Providing on-going care to people with mental illness in the community. (06,02,)
		Clinical management plan (10)
	Cultural Safety training	Awareness of relevant indigenous cultural/ beliefs (02, 01,03)
		Awareness of own culture/beliefs (01)
		Awareness of RAN culture (06,08)
Professional support	Mentor/orientation program	Experienced RANs and AHWs providing community specific orientation.(06,03,01,02)
		Formalised and rewarded mentor program for new RAN's (03.06,01,02,08)
		Performance appraisals including assessment of culturally appropriate behaviour. (03)
		Nationally standardised orientation (09)
	RAN recruitment / retention initiatives	Reducing work related stress and evidence of a commitment to adequate staffing levels of police and nurses (06,03)
		Employer aims to become an "employer of choice" (06,03)
		Honesty about violence (03)

Theme	Suggested tool	Tool detail
Organisational Measures	Back –up resources	Paid on-call night driver positions and/or 2nd nurse on call (01,13)
		Abolition of single nurse posts (07,10)
		Minimum of 3 staff at each clinic (03,01)
		Police presence in all communities (03,01,07,02)
	Policy and procedures	Boundaries set for acceptable behaviour. Consequences for violent behaviour (03,13)
		Nurse never attends a client under the influence without the presence of a reliable, sober person (02,03)
		Do not allow domestic violence victims into own house (02)
		Occupational violence and critical incident management policies and procedures (03,02)
		Leadership from management (13,08)
		Community consultation (09)
		RAN involvement (09)
	Safety Plan	Report and follow-up violence (03)
		Provide support for staff (01)
		Collaboration between health service/ community/ police (01,08)
	Post violence support	Follow-up reports of violence (03
		Provide support to individuals (13)

Hazard identification tool

The panel were asked to consider the use of a hazard identification checklist as a tool to assess the risk posed by their work environment. All responses were positive, however, it was noted that its value would be diminished if management did not have a commitment to actioning the hazards identified (03,02,). Additional comments displayed apparent frustration that it would be another job for the nurse to attend to (07) and that some resistance to its use may stem from the nurses being too busy or they know what to do already or " … it [violence] will never happen to them" (06). The benefit to new RANs was appreciated by a panel member, as an aid to developing a "safe practice approach" to the role of RAN (02). The frequency of assessment was seen as a potential barrier to its use (13). Flexibility of use and ability to adapt the tool to the situation was seen as vital to its success (08).

Some suggestions for areas to be included in the checklist were made and have been covered in the preceding discussion Hazard identification.

Exclusions

Some panel members made additional comments that were outside of the operational definitions used in this study, so not included in the above analysis. However, they are worth mentioning as may be included in future research with a broader scope. One panel member (08) described in detail the frustration caused by a limited scope of practice and described a situation where state legislation and employer policies and procedures were not sufficient to enable the health care staff to deliver the care needed to their communities even if they were trained. Specifically he spoke of medication management policies that prevented nurses from carrying or administering drugs, even in emergency situations. This frustration was linked to this project as he felt it was "bureaucratic violence" and could cause conflict with clients as they were unable to provide "…reasonable and expected treatment".

Consideration of data by expert panel

The aim of the second round was to assess the degree to which each identified hazard contributed to the risk of violence. The panel were asked to rate each identified hazard according to the risk management matrix described previously in this thesis; namely: minor hazard, moderate hazard, major hazard and extreme hazard. The option of 'not a hazard' was also included. This process also allowed the panel to validate the data presented by commenting on individual items.

The final draft was then sent to two pilot testers for their feedback and to ensure the questionnaire only took the stated 20 minutes to complete. One of the pilot testers only completed the first page and when contacted confirmed that she did not realise there was more. It was decided to state clearly at the start that there were two pages and to add an instruction at the end of the first page to click the "next" button. Minor amendments were made and the final questionnaire (see Appendix E) delivered to the panel.

Round two

In the second round, the experts' level of consensus was quantified using Likert scales and ranking. Quantitative data is presented using basic descriptive statistics that illustrate collective opinion (Keeney, et al., 2006). Data analysis aimed to measure the level of consensus amongst the panel and a level of 70% was applied. Comments provided by panel members have been incorporated into the description of each figure or table.

Hazard identification

In the hazard identification section, the items were grouped according to the themes environment, nurse, client and organisation. Each response was given a numerical value (not a hazard =0, minor hazard=1, moderate hazard=2, major hazard=3 and extreme hazard=4). The mean value for each item was calculated and the items within each theme were then prioritised according to the mean value. The results are represented in Figures 7 to 10.

Environmental characteristics

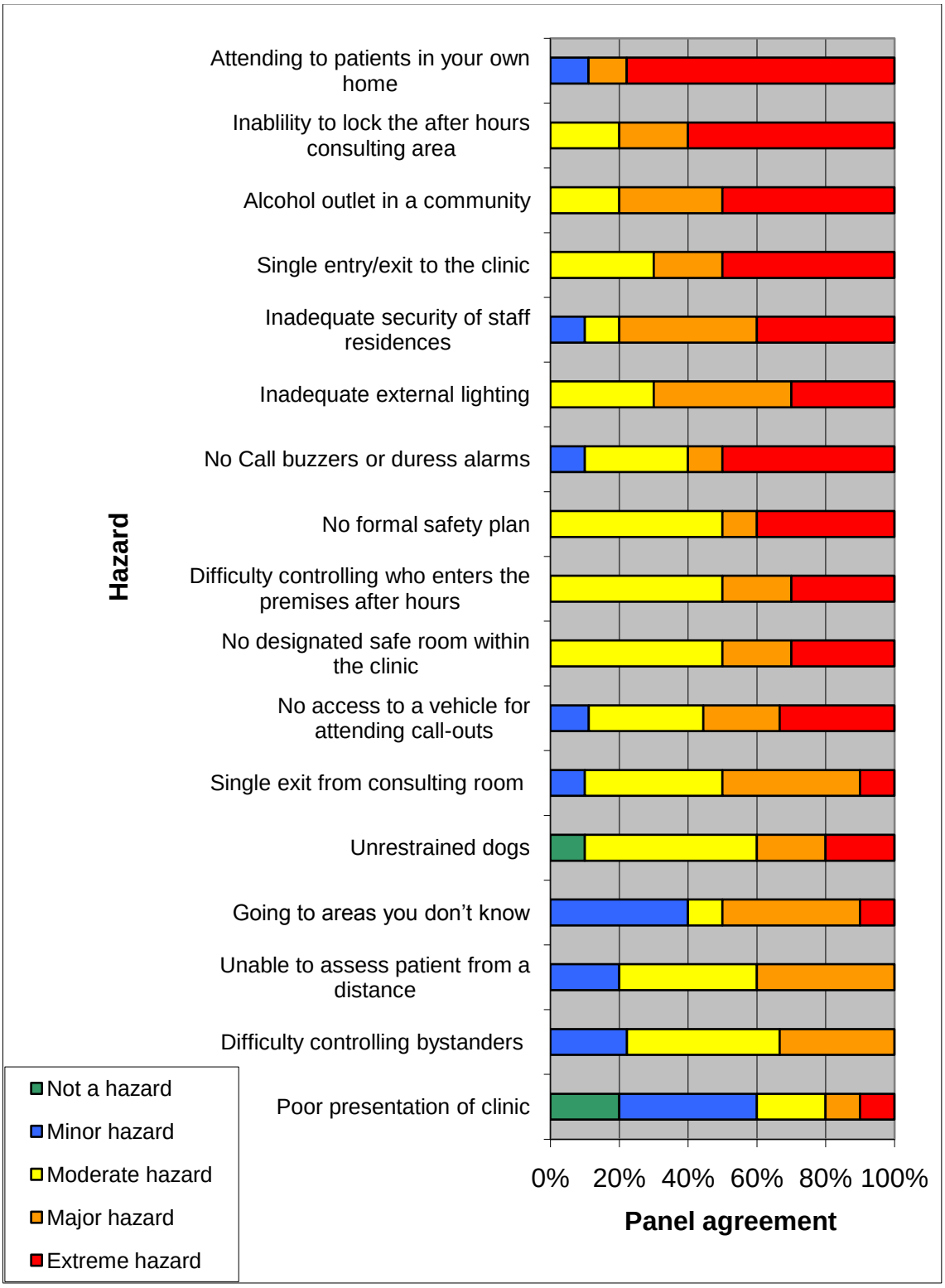

Figure 7 Environmental characteristics

Attending to patients in your own home was seen by most experts as an extremely hazardous situation, and maintaining good security measures a vital aspect of maintaining the personal safety of RANs. However, one panel member thought it was a

minor hazard and likewise another panel member indicated that maintaining a safe residence was a minor consideration. This choice was justified by the comment “I don't attend to patients in my own home if they are to be seen we go to the clinic” (13).

Issues around building design and maintenance were considered significant hazards for RANs. Inability to safely lock the clinic, having a single exit, inadequate external lighting and not having duress alarms were most commonly ranked as major or extreme hazards. Having a safe room was seen as slightly less important although 30% of the panel thought not having one was an extreme hazard. Controlling after hours access to the clinic which included the over-availability of keys and others using the building, was considered a moderate to extreme hazard. Being able to make an initial assessment from a distance either through a glass door or over the phone was a moderate to major hazard. Overall poor presentation of the clinic elicited a mixed response from not a hazard to extreme. It is possible that this response was due to ambiguity of the question as ‘poor presentation’ was not defined.

Alcohol outlet in a community was considered a major to extreme hazard. Having a formal safety plan was either a moderate or extreme hazard. Not being able to assess a patient from a distance, either over the phone or through a glass door, for example, was overall seen as a moderate hazard.

Not having access to a vehicle, unrestrained dogs and going to areas you don’t know was overall considered to be moderate to major with one or two panel members considering them to be extreme hazards. Forty percent of panel members thought going to unknown areas was a minor hazard. This variance may be related to the likelihood of this occurring.

The even spread of response from minor to major hazard makes it unclear whether the panel consider that bystanders cause security issues or may provide additional security and support for the nurse. One panel member highlighted this issue by commenting “It is a given for them [Aboriginal people], especially close family and skin to be there at times of concern. To attempt to deny that right, is asking for trouble and is not a culturally safe practice.” (8)

Nurse characteristics

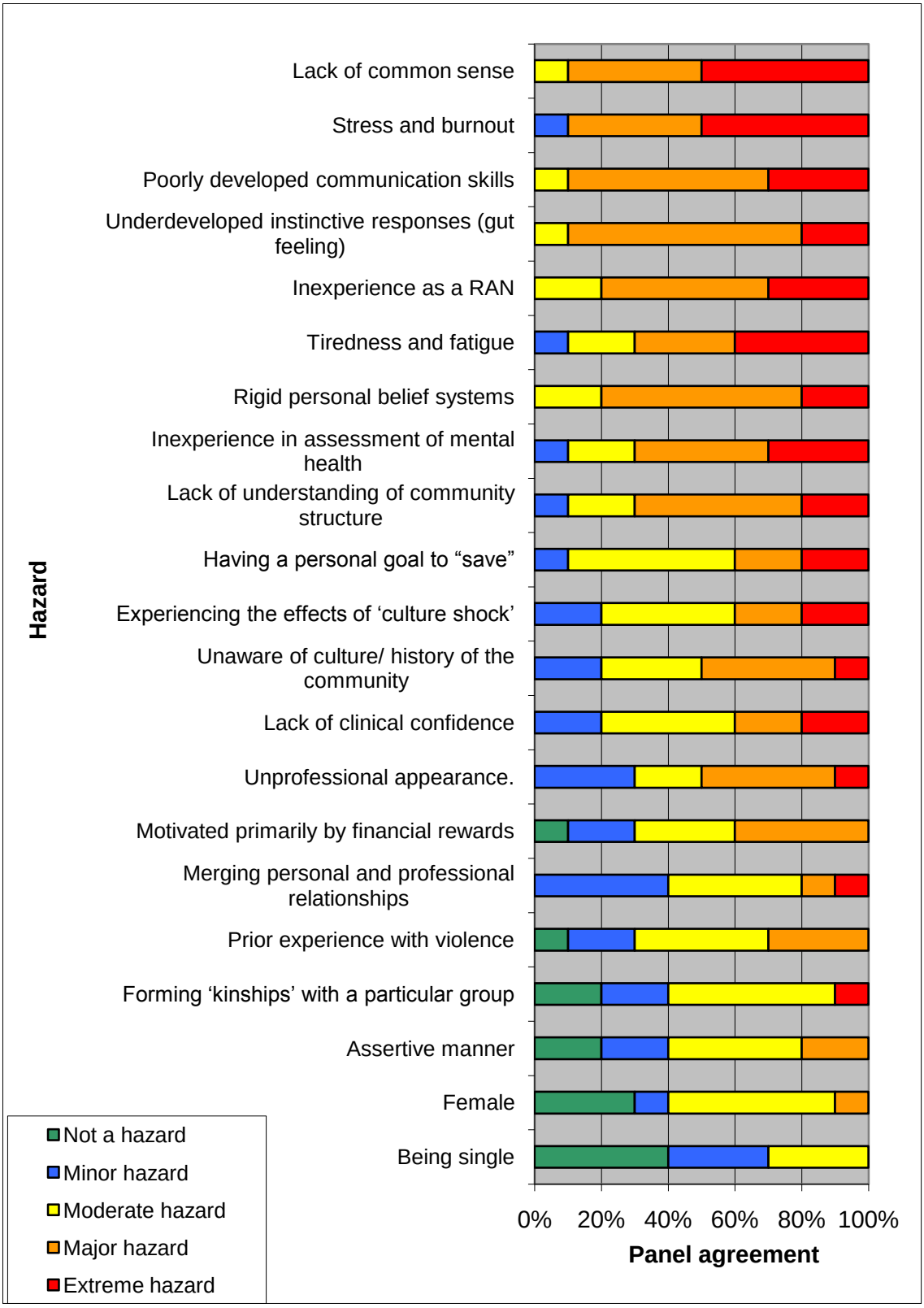

Figure 8 Nurse characteristics

The hazards related to RAN experience including: lack of common sense, poor communication skills and instinctive responses as well as mental health skills, had a majority of responses as major or extreme hazards. Stress and Burnout along with tiredness and fatigue also elicited a majority of responses of major and extreme. This indicates that the panel believe these to be the most significant hazards that increase the risk of violence. Other related issues including lack of clinical confidence, unprofessional appearance, assertive manner and motivated by financial gain, were perceived minor to moderate hazards. Prior experience of violence received a mixed response from not a hazard to extreme hazard.

Issues around cultural safety and awareness also feature prominently and were generally ranked as moderate to major hazards. These included: lack of understanding about the culture of the community, adhering to rigid personal belief systems including a desire to 'save' and experiencing culture shock.

Merging personal and professional relationships and forming "kinships" were commonly seen as minor to moderate hazards although two panel members were polarised believing that kinships could be either extreme hazard or not a hazard at all.

Being single and female were not seen as a significant hazard, although one panel member indicated that being female was an extreme hazard.

Comments from the panel on this section support the belief that experience and personality of the RAN influences the risk of violence (03,08),

> Some nurses have the ability to calm and diffuse a difficult and potentially risky situation while others ignite the situation. From my experience this is about personalities but is an acquired skill with good orientation and education in assessing and diffusing a situation (10).

Definition of "experienced" RAN

The panel's responses showed that 70% considered 'more than 4 years' employment as "experienced". Also included by a panel member (9) was a reference to the definition of RAN by CRANA*plus* (Council Remote Area Nurses Australia, 2003):

Panel members recognised that experience is gained at different rates and that some may be experienced after two years whereas others may take ten (1,10). Advanced communication skills and involvement in community life were also identified as being aspects of "experience" (3). It was noted that appreciating the skills and strengths and diversity of the team and adopting a team approach is the best way to work as a RAN (13).

The general conclusion of the panel is that it takes around 4 years to build up enough knowledge, respect and trust of the community and culture and to develop skills such as communication and intuition sufficiently to be called “experienced”.

Client characteristics

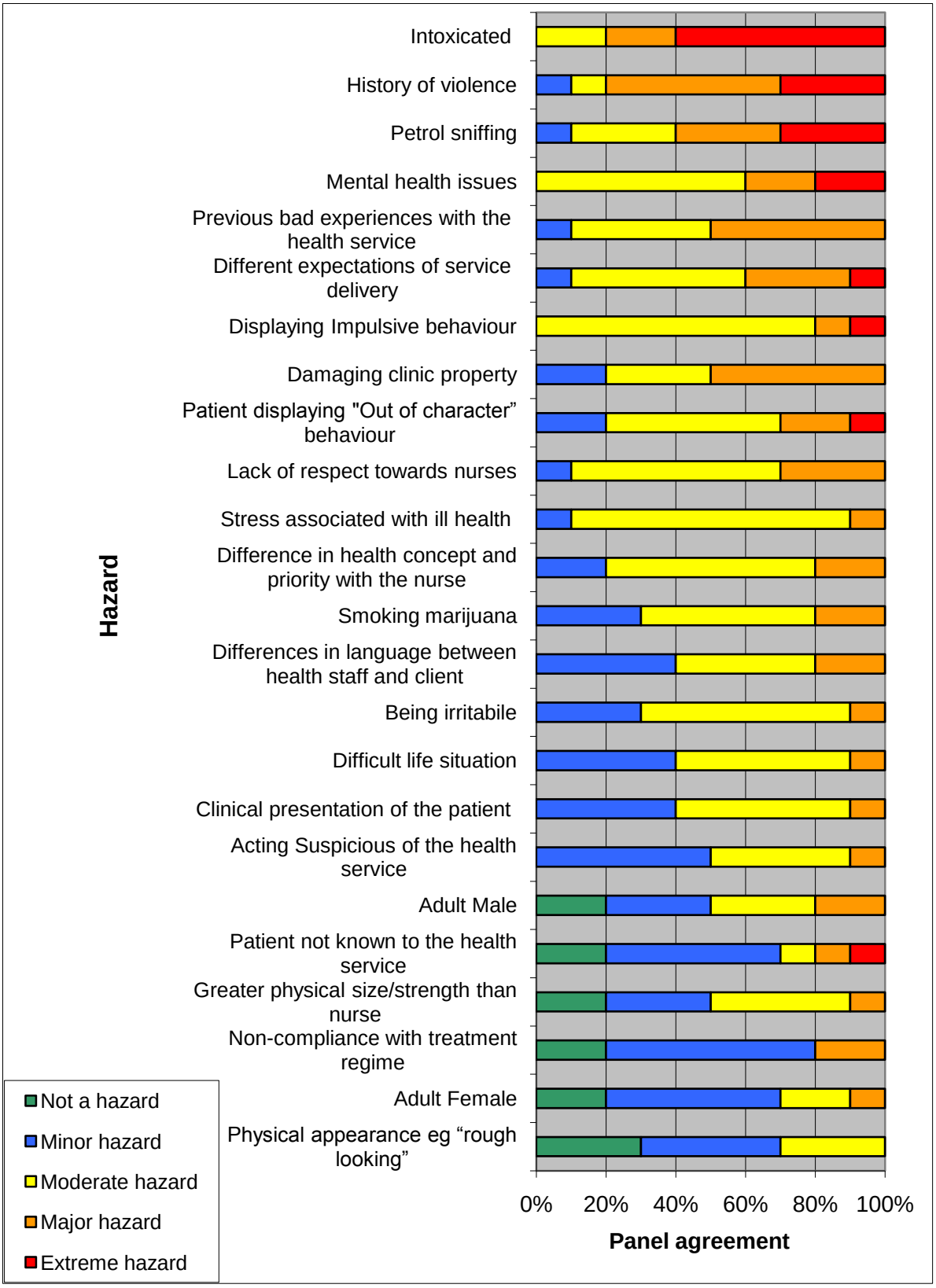

Figure 9 Client characteristics

Intoxication, petrol sniffing and to a lesser extent marijuana presented the greatest risk of violence towards RANs. A history of violence and mental health issues were also seen as significant hazards with the majority of responses as moderate, major or extreme. One panel member clarified their choice by explaining that mental health issues became a greater risk factor when the client was noncompliant with medication or had issues with substance abuse (13).

Different expectations including previous bad experiences and priorities of the health service increase the risk of violence with the majority of respondents indicating it as a moderate to major hazard, and one panel member describing a situation where service was denied for minor ailments after hours as an event that can trigger violence (13). Body language and behaviour, were seen as good indicators of risk. Impulsive, disrespectful, irritable and suspicious behaviour as well as someone who was acting 'out of character' generally received a moderate ranking. Impulsive behaviour was identified as the greatest indicator. Language differences between the nurse and client were recognised as contributing to conflict. The stress associated with ill health as well as the client living in a difficult life situation were rated as moderate contributors to the risk of violence.

Physical appearance including, gender and size were rated as very low hazards with most responses being minor or not a hazard. This was also the case with the patient who was not known to the health service or was non-compliant with their treatment regime, however, two panel members selected major and extreme hazards for patients not known to the health service.

Organisational characteristics

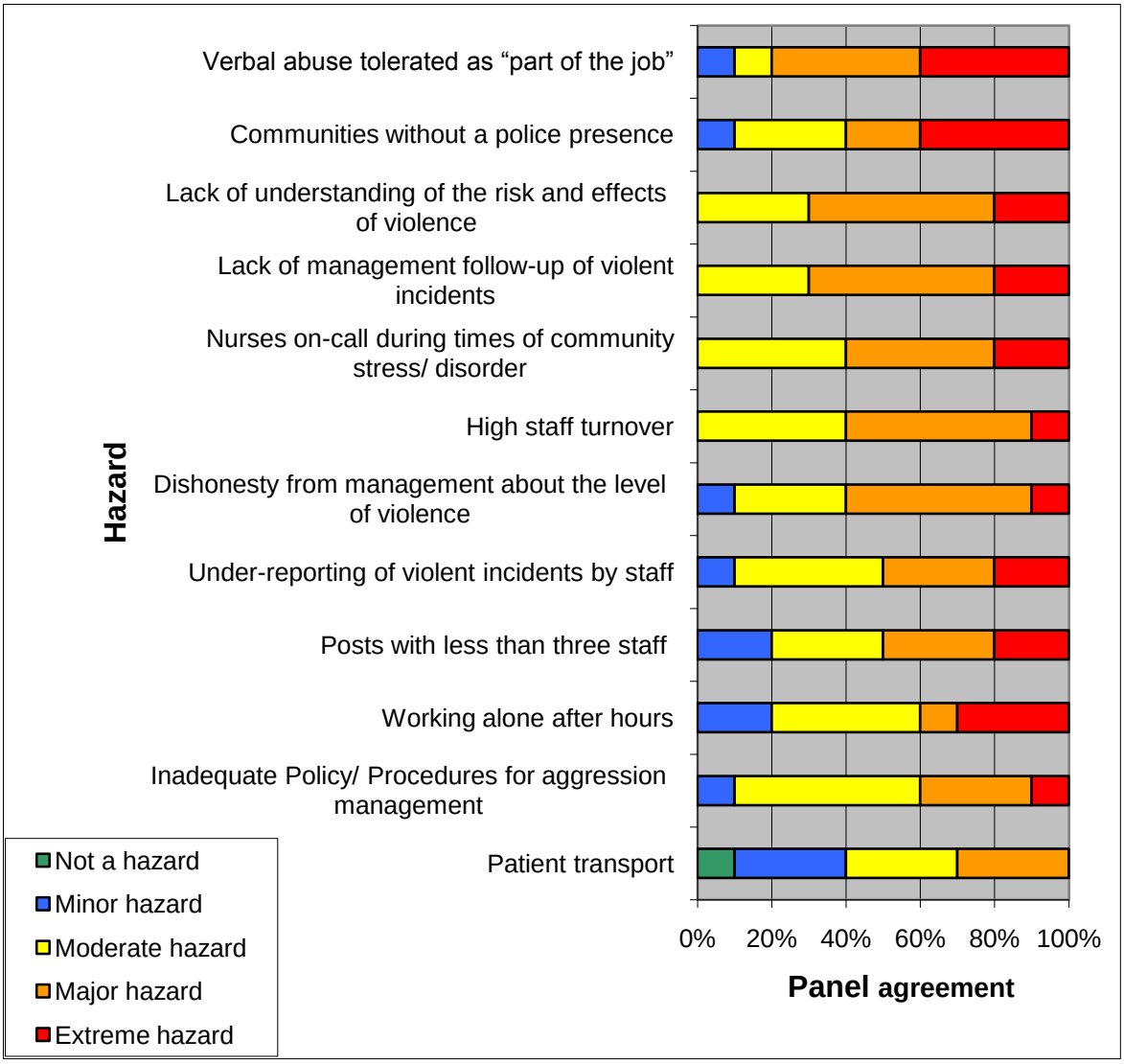

Figure 10 Organisational characteristics

A work culture that tolerates verbal abuse is seen as the most significant hazard. However, one panel member rated it as a minor hazard. Recognition of the increased risk to nurses when they are required to be on-call during times of community stress and disorder is shown by an even spread of risk between moderate, major and extreme. Under-reporting of violent incidents, a lack of understanding and follow-up from management, as well as dishonesty about the risk and effects of violence were considered to be moderate to extreme hazards for RANs. Inadequate policies and procedures for aggression management were considered organisational hazards with a moderate to major impact on the risk of violence, however, all these hazards were considered extreme by some panel members. One panel member indicated that health

centre managers should implement consequences for abusive behaviour and uphold these as evidence of support for staff (13).

High staff turnover is identified as being a moderate to major hazard in terms of increasing the risk of violence. Having less than three staff members at a clinic appears to be less of a hazard than communities without a police presence. Working alone after hours was most commonly seen as a moderate hazard, however, 20% of the panel felt it was minor and 30% considered it an extreme hazard. Patient transport was generally seen as a minor to moderate risk.

Control measures

Results from the control measures section are displayed in Tables 4 to 8. Responses in the ‘very useful’ and ‘essential’ categories were combined to give an overall level of consensus.

Table 2 Education and training required to improve personal safety for RANs

Education and training	Consensus %
Engaging community support when providing care	100
Education regarding indicators of traumatic stress reactions (PTSD)	90
Creating 'Clinical Management Plan' for patients with history of violence	90
Awareness of relevant indigenous cultural/ beliefs	90
Understanding of power relationships that exist between the nurse, health service and the community	80
Mental Health assessment	80
Knowledge of the health service history and politics (Corporate knowledge)	80
De-escalation techniques/ aggression management skills courses/ workshops	80
Awareness of own culture/beliefs	80
Self-defence techniques	70
Awareness of RAN culture	70
Assessment of the work environment for hazards	70
Behavioural effects of alcohol/drugs	60
Identification of behavioural precursors to violence	50

Training in how to engage community support when providing care, achieved unanimous support as being very useful or essential education for RANs. Creating clinical management plans and conducting mental health assessments are also activities done in consultation with the family/community and should be included in training programs.

Education relating to cultural safety topics were regarded as important. These included knowledge of relevant indigenous culture, power relationships, awareness of own culture and knowledge of the history and politics of the health service. Specific education about de-escalation techniques, self-defence techniques, symptoms of post traumatic stress disorder and how to assess the work environment for hazards gained at least 70% of the panels support as very useful or essential knowledge for the RAN.

The need for education regarding the behavioural precursors to violence did not reach the required level of agreement, with only 50% of the panel members indicating that it was an important topic for training.

Table 3 Professional support required to improve personal safety for RANs

Professional support	Consensus %
24 h access to Bush Crisis line	100
Evidence of a commitment to adequate staffing levels of police and nurses	100
Reducing work related stress	100
Experienced RANs and AHWs providing community specific orientation	90
Employer aims to become an “employer of choice”	80
Formalised and rewarded mentor program for new RANs	80
acknowledgment of RAN as a victim of a blame free traumatic incident	70
Performance appraisals that include assessment of culturally appropriate behaviour	70
Nationally standardised orientation program	40

Items related to providing professional support were strongly supported, with one panel member stating that in an ideal world they would all be ‘essential’ (10). The Bush Crisis line is a significant avenue for support along with evidence of efforts to improving workforce recruitment and retention issues. This will in turn reduce the levels of stress all of which gained unanimous support from the panel. Support for employers to work towards gaining ‘employer of choice’ recognition was also evident by the panels responses. Acknowledgement of the RAN involved in a violent incident as being the victim of a blame-free traumatic event also had support from the panel.

Orientation and ongoing support in the form of a mentor program also received good levels of support. A nationally standardised orientation had some support but did not reach the required level of consensus. This could reflect the strong support for local onsite orientation (9). Including an assessment of culturally appropriate behaviour during performance appraisals was also supported by the panel.

Table 4 Organisational responsibilities to improve personal safety for RANs

Organisational responsibilities	Consensus %
Action from management in implementing strategies to reduce the risk	100
Regularly updated contact list	100
Abolition of single nurse posts	100
Recruitment of RANs based on specific selection criteria	100
Police presence in all communities	100
Consequences for violent behaviour	90
Boundaries set for acceptable behaviour	80
Paid on-call night driver positions and/or 2nd nurse on call	80
Formal debriefing process	80
Check-in system if working alone	80
Identification and documentation of clients with a history of violence	70
Management plan for drug seekers	70
Plan for management of nuisance phone/intercom calls	60
Pre-arranged distress message	60
Minimise need to attend call outs away from the clinic	50
Disincentive for patients accessing service after hours	40

Action from management was seen as the most important organisational responsibility in improving safety for RANs. Examples were provided by the panel throughout this project where hazards were identified and reported or suggestions given and management did nothing (3). Recruitment of the ‘right’ staff in the first instance and not ‘just taking anyone’ also received unanimous support.

Boundaries set for acceptable behaviour and consequences for violent behaviour were seen as strategies to improve personal safety. Identifying and documenting clients with a history of violence or drug seeking received support as being very useful or essential. However, panel members were concerned about labelling people as ‘violent’ or ‘drug seeking’ and commented that these situations may be a legitimate response to particular circumstances at that time and place and that these labels may ‘stick’ (8,1).

Having a police presence in all communities along with the abolition of single nurse posts achieved unanimous support. In addition, support for a second nurse on-call was broad, however, concern about fatigue that as a result increased the risk of violence was stated (3). Establishment of a check-in system received 80% support, however, implementing a pre-arranged distress message and a management plan for nuisance

phone calls did not reach the agreed level of consensus. A formal debriefing process was supported by the panel.

Minimising the need to attend call-outs away from the clinic and implementing financial disincentives to clients accessing the health service after hours were not generally supported as strategies to reduce the risk of violence.

Table 5 Policy and procedure requirements to improve personal safety for RANs

Policies and Procedures	Consensus %
RAN involvement in policy and procedure development	90
Regular evaluation of policies and procedures	90
Critical incident management policies and procedures	90
Policy stating that nurse never attends a client under the influence of alcohol/drugs without the presence of a reliable, sober person	90
Flexible policies that can be adapted to individual communities	90
"Zero tolerance to violence" policy	80
Policy stating that nurses do not attend patients in their own home	70

Although a "zero tolerance to violence" policy reached the prescribed level of consensus there was a panel member who indicated that it was "not useful". Another panel member highlighted the difficulty of implementing a zero tolerance policy. She states that "…*previously the IC [nurse in charge] would in places close the clinic until the abusive community member apologised to the Nurse."(13)* This no longer happens and the staff do not feel supported (13).

RAN involvement in the development and evaluation of policies and procedures including the management of critical incidents, was generally seen as essential. Involving community leaders in this process was also identified as beneficial (1). However, the comment was made that having policies and procedures in place was of lesser importance than having adequate staffing levels (13). Flexibility with policies was strongly supported, however one panel members pointed out that differences in policies between health services may be confusing for a highly mobile population (3). Not attending an intoxicated patient on your own is a policy supported by all but one panel member, however having a policy that states that patients should not be seen in staff residences only gained 70% support. These are policies currently in place for NT government employees (Northern Territory Government, 2009).

Table 6 Community involvement required to improve personal safety for RANs

Community involvement	Consensus %
Community involvement in planning and implementing consequences for violent behaviour (eg: withdrawal of health services, conditions imposed on individuals)	100
Collaboration between health service/ community/ police in developing violence reduction strategies	100
Involvement of community leaders in staff orientation	90
Formal community consultation process established	90
Development of mutual understanding of service expectations	90
Collaboration in the development of a community safety plan	90

Community collaboration and involvement was seen as a vital aspect in managing the risk of violence in remote communities (10). Concern was raised regarding the effect on the community leaders and their families when the need arose to enforce the policy. The influence of community leaders may be diminished in some communities and there may be retaliation towards those leaders and their families (13). Involving community leaders in orientation programs for staff; establishing a formal consultation process with the community to develop a safety plan; violence reduction strategies; consequences for violent behaviour and development of a mutual understanding of service expectations received overwhelming support with 90-100% of panel members considering these control measures to be very useful or essential.

Round three questionnaire

The third round questionnaire aimed to broaden the researchers' understanding of several key topics and the responses are summarised below.

Safety plan

The panel were asked to describe the essential components and barriers to creating a community specific safety plan. The plan should include procedures for obtaining help in an actual or potentially violent situation by listing reliable community contacts (13) and include local non-indigenous contacts as at times large numbers of indigenous community members may leave the community with little warning (13). Having a loud siren at the clinic for raising the alarm (13), along with nominated night drivers (13) and identification of safe areas (06), should also be included. A formal evacuation plan (06) should be in place.

The plan needs to identify that there are different roles and subsequently different levels of danger in a violent situation (02). For example, in a riot, the police, health staff and community elders are likely to play different roles in diffusing and resolving the incident. A safety plan should also provide guidance for behaviour in particular contexts (02) for example; attending call-outs at night or travel to particular areas. A process for prosecution of offenders (06) and consequences that are agreed to by the community (06) are also important facets of a community safety plan. The inevitability of being involved in violence in the community – even indirectly was highlighted by one panel member who stated, "the clinic staff are always present, have access to phones, speak English and can communicate with authorities - they nearly always end up being the people to go to for any crisis" (02).

Consultation and involvement with all stakeholders was identified as an essential step in developing a safety plan (02,07,06). These stakeholders included: police, school, shire, shop, elders, health board, night patrol, key businesses and representatives of various sectors of the community, particularly identifying those with authority and ability to speak for the community (08). This step aims to create guidelines with agreement from all stakeholders (07). Consultation (07,02,08,06), feedback (07) and education (08) of the community as a whole regarding the safety plan. There may be a role for independent assessors (08) or consultants to aid in this process. It would be useful to evaluate the effectiveness of a safety plan and this would include collecting baseline information about the level of violence (08).

The barriers to creating a safety plan are many and varied. Community acceptance (07) of the plan may be difficult due to different expectations (02), lack of trust (08), commitment (08) and responsibility (13) amongst the community and health service.

Lack of volunteers willing to be contacts (13) and uncertainty of who is in the community (02) along with potential for problems for community members required to enforce consequences (payback) (13) may be significant deterrents to community involvement. Inclusion of people with a history of violence in the process was identified as an important but difficult aspect of a community plan (06).

The development and implementation of a safety plan may be hampered by a lack of interest from health centre staff (06), an employer's slow response to issue raised (06) and the potential for this to be a very long process (07,13). The time and effort required to develop and implement a safety plan should be paid so as not to put additional pressure on clinical staff (08). Understanding of the importance and effectiveness of a safety plan is undermined by the under reporting of violent incidents by staff (06).

Consequences for violent behaviour

The use of consequences as a deterrent to violent behaviour was suggested by the panel in previous rounds. In this third round the panel described possible consequences and issues related to their enforcement. Reporting incidents of violence to management (02, 13) and the police (02,07,13) with prosecution possible if the nurse is willing (13); were identified as consequences used by RANs. There is a lack of confidence in the support a RAN will receive from an employer if violence is reported or goes to court (13). Closure of the clinic (02,06) and/or the shop (02) along with evacuation of health staff from the community (02) were enacted for threats to staff safety. It was suggested that while removing services punished the whole community it may prompt the community to deal with troublemakers themselves (02). Other consequences involved perpetrators of violence having limited access to the clinic. For example, only in an emergency (07) or being required to attend with a responsible person (08). Concern was raised that denial of access to health service breached the duty of care a health service has to its community (08,06). Consequences need to be enforced immediately (06).

Using authoritative elders (02,13) and/or the police (02) to talk to offenders and taking the offender to an outstation (13) were also identified by the panel. Cultural 'payback' (07,13) which may include spearing, flogging or apologising was described by some panel members. Payback as a consequence was not always enforced however, due to fear that the enforcer may then become victim to retaliation (07). The police may also avoid prosecuting offenders for the same reason (02). An account of 'payback' was given by one panel member

> On the road was an individual shouting like a bull four spears in hand. The police had taken the underage girl from him, his father came out of the

> house...[the] father over powered the boy and with a broken spear flogged him in about five minutes – all over, everyone inside again. The boy went into the bush SHAMED(13).

Vandalism and erratic driving may involve community imposed confiscation of car (07) or payment deducted from Centrelink allowances (02). Panel members commented on the importance of acknowledging power issues that exist between the health service and the community (08,06). It may be inappropriate for RANs to become involved in the implementation or enforcement of consequences (08).

History of violence

Information about community members with a history of violence was not often passed on (13,06) but when it was it occurred either at orientation (02,06,13) or handover between shifts (02,13). Occasionally, notes were made in the patient's medical file (02) or with an 'alert' sticker (02,03). Some health services have computerised records and an 'alert' can be included as part of an individual's file (07,13). Trespass orders are possible (07) and identifying community members who are mentally ill (13) was also passed between RANs. One panel member suggested having photos or a list of known violent offenders in the staff office to inform new staff members of those in the community with a history of violence (13). Potential for breaching an individual's right to privacy was highlighted (08) but negated by another panel member who thought that staff safety was more important than the rights of a violent offender (13). The dynamic nature of violence was recognised by a panel member who stated that " We need to be aware of the reasons people can be violent; Intoxication,...pain, frustration, biochemical derangement, etc" and that awareness of and intervention in these factors may diffuse the situation (08).

Summary

This study generated qualitative data in the first and third rounds. Content analysis revealed hazard themes within the framework of environment, nurse, client and organisation. Suggested control measures were grouped according to education and training, professional support, organisational responsibilities, policies and procedures, and community involvement. The second round assessed consensus amongst the expert panel as to the degree of risk posed by each hazard and the usefulness of the suggested control measures.

Chapter 5: Discussion

Introduction

This study used the Delphi technique to explore the issue of violence towards RANs. The results are informed by a panel of experienced RANs and provide a perspective not described in previous studies. Adopting a risk management approach, with a framework of the environment, nurse, client and organisation as characters in a violent interaction has provided insights into the identification of potential hazards and measures that may reduce the risk of violence towards RANs. The first part of this chapter discusses the findings in relation to the published literature. The second part of this chapter describes the limitations of this project and recommendations for further research.

Hazard identification

Identifying hazards is the first step in a risk management process. It allows consideration of risk based on the likelihood and consequences of that hazard occurring.

Environment:

The working environment was considered by the panel and two themes emerged, these were building design including security features available and home or 'out of clinic' visits.

Building design/security

General lack of security features within clinic buildings were identified by the panel as increasing the risk of violence for RANs. These features included inadequate external security lighting, no provision of duress alarms, difficulty in controlling who had access to the clinic after hours, and inability to lock the building. This was supported by a New Zealand study of District [community] Nurses that revealed that they had expectations that their base would be secure and that this could be achieved by limiting access to the building after hours by keeping a minimal number of keys in circulation, keeping the building neat and tidy with vegetation cleared well back from access routes and maintaining bright security lighting to eliminate hiding places and discourage loitering. Likewise, other buildings and areas that are accessed by staff after hours need to be well lit and maintained e.g. rubbish bins, storage areas (Wilkinson & Huntington, 2004).

Building design plays an important part in the prevention of violence. Factors such as high temperatures and humidity, poor lighting and air quality, high noise levels,

crowding and an audience, may be enough to spark off an incident (Wand & Coulson, 2006). In addition, a ready source of potential weapons such as stethoscopes and other medical equipment may offer opportunities for violence. It is essential, therefore, that clinical areas are screened for potential weapon use (Ferns, et al., 2005). Being unable to make an assessment of a patient from a distance, for example, through a glass barrier or over the phone, was identified as a moderate hazard by the panel. A study of General Practioner's highlighted concern over the use of overt security measures such as barriers or security guards as they may damage the doctor-patient therapeutic relationship and result in mutual suspicion and misunderstanding (Magin et al., 2008b). It is possible the panel shared this concern and rate the risk lower as it outweighs the benefits to the relationship.

The panel identified that having a plan of escape should an incident occur, was an important strategy in dealing with violence in the remote area workplace. Having a plan may be particularly important for new and relieving staff as they are unlikely to have their own support networks within the community. A pre-considered escape route from all parts of the clinic was thought to be vital by the panel. Having only one exit from a clinic building was also identified as a building design hazard. A designated safe room must also be identified if it is impossible to go outside. This room should be able to be locked from the inside and have a telephone with emergency contact details obviously displayed (National Health and Medical Research Council, 2002). It has been suggested that often it is up to the individual nurse to identify and approach these contact people. With high staff turnover this becomes a difficult task as it relies on community knowledge and trust to be effective (personal communication, S.Lenthall, 11/02/11).

Poor presentation of the clinic evoked a wide range of responses from the panel. This may be because the presentation of the clinic buildings may generally be good. A comment was made by one panel member that material objects or property are not valued by Aboriginal people in the same way as non-aboriginal people (08), therefore the presentation of the clinic may not have the same potential influence on undesirable behaviour as identified by Wilkinson and Huntington (2004).

Controlling bystanders and large numbers of people accompanying a client during a call-out was identified as a hazard by some panel members. However, others may consider having other people around as supportive to the nurse and beneficial to the patient. Chaplin and Allison (1998) state that the reason why the bystanders are present is significant in the assessment of risk, for example, concerned family members as opposed to intoxicated people at the public bar.

Home visits

Community health nurses work primarily with people in their own homes in "unpredictable, uncontrollable and uncertain environments" (Skillen, Olson, & Gilbert, 2003 p.93). A study of district nurses in New Zealand identified that the client is in a position of power over the nurse by virtue of being in their own environment (Wilkinson & Huntington, 2004). This is seen as a significant factor in considering the risk of violence, as is the intimate nature of patient care conducted in these visits. Several studies have found that personal touching as is often necessary when delivering nursing care, is associated with a high risk of assault (Fisher, et al., 1996; Wilkinson & Huntington, 2004). According to the panel, the risks associated with out of clinic call outs were related to the availability of alcohol and subsequent level of violence in the community. Going to unknown areas was an area of disagreement amongst the panel, this may be linked to the likelihood of this occurring. As all panel members are experienced they may know their territory well and this may be a rare occurrence. One of the panel members regularly relieves permanent staff across many communities and would encounter "unknown areas" frequently, this panel member considered unknown areas to be an extreme hazard.

Violence towards General Practitioners (GPs) in Australia is common. A small exploratory study by Magin et al. (Magin, Adams, Ireland, Heaney, & Darab, 2005) found that GP's felt more vulnerable when attending house calls, when seeing increased numbers of patients not known to the practice, and working after hours in isolation. The Northern Territory Government policy regarding staff on-call safety considerations (Northern Territory Government, 2009) advises staff to assess the need to leave the clinic carefully and encourage clients to find their own way to the clinic for treatment. The policy described the use of a "responsible community member" to act as an escort for after-hours community call outs and to avoid the use of other clinical team members to avoid fatigue of the team.

Not having access to a vehicle to respond to call outs was identified by the panel as a moderate to major hazard. Communication devices such as mobile/satellite phones, radio and personal phone are recognised as important tools when leaving the relatively controlled area of the clinic. Detailed call-in check systems and prearranged distress messages may help workers outside the clinic environment (National Health and Medical Research Council, 2002). Special note is made of repeated phone or intercom calls for assistance after hours (Northern Territory Government, 2009; Phillips, 2007). These may be an attempt to lure staff into a dangerous situation.

Unrestrained dogs were reported to be a risk to personal safety (Chaplin & Allison, 1998; Skillen, et al., 2003), but the panel disagreed as to the level of risk posed by

dogs with a range of responses from ‘extreme hazard’ to ‘not a hazard’. This may relate to the likelihood of encountering dogs or personal confidence when interacting with dogs.

Other suggestions specific to out of clinic consultations found in the literature include: leaving the vehicle engine idling with the windows up and doors locked until the risks have been assessed, keeping valuables out of sight and carrying a robust torch. If it is deemed safe to leave the vehicle then the staff members should; enter buildings with caution, noting the exits and switching on lighting where possible. Staff are advised to leave immediately if weapons or firearms are seen or if the situation appears to be unsafe. (Northern Territory Government, 2009). Skillen et al. (2003) suggested, wearing an identification badge with first name only, wearing minimal jewellery, dressing conservatively and asking the client to leave an outside light on and meet them at the door when attending home visits. Asking for accurate directions, carrying keys in a defensive manner and planning home visits for the morning where possible were also suggested.

Attending to patients in a RANs private residence was seen by the panel as an extremely high risk practice, and that inadequately secure residences was a significant hazard. This is supported by some Government Departments actively discouraging it through policy statements (Northern Territory Government, 2009). Anecdotal evidence suggests that there have been a number of serious assaults in RANs private residences and that security measures such as security screens and locks may be deficient in many areas (personal communication; S.Lenthall,15/10/10). According to Fisher et al. (1996), living in employer provided accommodation carries a greater risk to personal safety; in addition, there has been at least one serious assault in a RAN’s accommodation where the level of security provided was criticised (Anonymous, 2008).

Nurse

The panel were asked to consider the role of the nurse in violent incidents. Characteristics that were considered hazardous were grouped into several themes. These themes are; RAN experience, cultural safety and personal/professional relationships and support.

RAN experience

The panel indicated that inexperience as a RAN is a significant hazard and that experienced RANs were better protected from violence due to their knowledge and respect of the community and its culture. This is supported by Murphy (2004) who argues that more experienced nurses better predicted the risk of violence, but a study of Queensland nurses (Hegney, et al., 2003), found no significant correlation between length of service and incidence of violence from patients or visitors. Aspects of experience include: length of service as a RAN, well developed communication skills and 'gut feeling', common sense, clinical confidence and culturally safe practice. Absence of these factors was seen as significant hazards by the panel. No accepted definition of an "experienced" RAN was found in the literature. However, a panel member referred to CRANA*plus*' definition of a RAN (Council Remote Area Nurses Australia, 2003) (9), and efforts to credential RANs may provide a framework for measuring experience. As 'experience' was a commonly used term, it was decided to include a question to the panel with the specific purpose of better understanding of what was considered 'experienced'. When asked how long it took to become an experienced RAN the panel responded with a timeframe of four years, although some panel members recognised that experience is gained at different rates (1,10). This is pertinent when considered along with recent workforce data that shows the most common length of time spent as a RAN is two months and the average is 3.2 years (Rickard, 2010). This may, at least in part, be an explanation for the rise in incidence of violence reported by Opie et al. (2010).

Common sense was seen as a vital skill for RANs, by the panel. Common sense can be defined as either "Good sound practical sense; combined tact and readiness in dealing with the every-day affairs of life " or "the general sense, feeling, or judgement of mankind, or of a community " (Oxford English Dictionary, 1986). According to prominent Nursing theorist Patricia Benner " Nurses practicing at the expert level have mature practical knowledge about what to expect of particular patient populations" (Benner, et al., 2009p.153). This knowledge sparks early recognition when things go awry (Benner, et al., 2009). This also raises the question: is common sense a skill that should be displayed by a RAN from recruitment, is it developed with experience, or can it be taught? One panel member commented in round two that common sense was an

acquired skill and that good orientation and education regarding violence risk assessment and de-escalation skills would be helpful (10). A study by Magin et al. (2008a) which explored the framework GPs used to assess their individual vulnerability to violence found that one major aspect relied upon by the participating GP's was that of intuition or gut feeling about the risk posed by a patient or situation. However other participants identified that this may be due to attention to the 'markers' of risk, such as: general appearance (eg: rough looking), gender (male),greater physical size/strength, illicit drug use, age (young), psychiatric illness, predictability and presence of companions.

Cultural safety

Lack of the necessary skills and experience needed when working in a cross-cultural environment and a lack of understanding of the specific culture of the community, which includes its, history, politics, family hierarchy and previous experiences with the health service, were identified as hazards by the panel. Cultural Safety is a term used to describe nursing care that maintains a person's cultural integrity and recognises that the nurses own culture impacts on nursing practice (Eckermann et al., 2010). Culturally safe practice is particularly important in remote areas as the health service provided is generally the only option open to residents. It therefore, has to be accessible and acceptable to all community members regardless of age, gender, language and ethnicity. In addition, many health services are provided based on the western biomedical model, which is concerned primarily with the diagnosis and treatment of specific ailments using a scientific paradigm and is criticised for not adequately considering the psychological and social aspects of health (Germov, 2009). This may lead to conflict as power differentials exist between the healthcare provider and the patient (Bourke et al., 2004) as well as differences in service expectations and health priorities between the patient and nurse.

Conflict can arise in a cross-cultural environment due to language and communication differences and differing expectations from both parties. Offence may be caused inadvertently by a lack of knowledge of cultural and spiritual beliefs. For example, in some aboriginal communities the name of a recently deceased person must not be spoken (Trudgeon, 2000); lack of knowledge of and respect for this belief may cause conflict between a nurse and client. City nurses adapting to the very different remote context may experience culture shock (Muecke, Lenthall, & Lindeman, 2011). This is exacerbated by living in the community that they work in. Cross-cultural adjustment may cause significant anxiety, confusion and emotional distress and may compromise clinical care and cultural safety (Morgan, 2006; Muecke, et al., 2011). The lack of orientation and cultural awareness education for RANs was identified in 1996 (Fisher,

et al., 1996) and is still being stated as a significant problem by the panel. Cultural safety training has been included in under-graduate university nursing curriculums since the early 1990's, however, the significant proportion of older RANs, most of whom trained before the advent of 'cultural safety' means that it is likely that many will not have had any formal cultural safety training at all. Online cultural safety courses are offered by the Council of Remote Area Nurses Australia (2010b), and the Combined Universities Centre for Remote and Rural Health (2010) but it is not known how many RANs are completing these courses or what effect this knowledge is having on their practice.

The panel identified that some nurses have a "goal to save" indigenous communities and that this attitude which has also been referred to as "missionary zeal" (Fisher, et al., 1996), may be harmful to relationships or put the nurse in an inappropriate situation. For example, interfering in cultural 'business' in order to treat a patient. The phrase "goal to save" may also be a reference to the tension many public health practitioners feel when working in Indigenous communities that is described by Kowal and Paradies (2005). The authors describe this tension as arising from differing approaches to health in terms of self-determination and right to define one's own notion of health and the universal idea of health as living a long life without disease. The authors also point out that current approaches to health are based on an obligation by the State to provide healthcare with a moral obligation by the citizen to maintain their own health. Culture clash may occur when RANs seek to change the behaviour of individuals or communities in a manner that disrespects the right to make 'unhealthy choices'. This interpretation of the phrase 'goal to save' recognises the importance of understanding the community, its history and culture as well as self-reflection and understanding of one's own culture, community and history. Understanding the political and historical environment of where you work may develop empathy and sharing this type of information with colleagues may better prepare them for such incidents (National Health and Medical Research Council, 2002). Further research may shed light on this issue and provide guidance for the cultural safety education of RANs.

Working as a RAN primarily for the financial rewards was identified as a minor to moderate hazard and this may be reflected in the RANs attitude to their work and community.

Personal/professional relationships/support

Separating personal and professional relationships was identified by some panel members as a protective measure and a way of avoiding conflict, when living and working in small communities. However, other panel members thought that such separation was unavoidable and becoming a part of the community lead to increased

trust and respect. It has been noted that RANs provide a health service and live within "…a complex web of social relations, cultural history and socio-political networks." (Bourke, et al., 2004,p.184). Perhaps the variation in response from the panel members, in terms of the level of risk involved, is simply a reflection of their own experience. A response from a panel member in the first round indicated that personal relationships may exclude some members of the community either from a social hierarchy point of view or perhaps even concerns about confidentiality..

Unprofessional appearance was mentioned but not described by the panel and there is a range of response as a result. In the first round the suggestion was made that having dress code may be protective. It was not clear if this meant wearing a uniform or was a reflection of the casual nature of Remote Area Nursing. There may be issues of what is culturally appropriate dress standards, for example; wearing shorts may be seen as provocative. Self awareness and an appreciation of how the staff member presents his or herself to the client may help prevent misunderstandings. Nurses should also routinely assess their appearance and attire in relation to potential weapon use for example: ponytails can be used to pull down, stethoscopes/ necklaces to strangle, inappropriate footwear impeding escape, scissors as weapons (Ferns, et al., 2005). Having an assertive manner did not reach consensus amongst the panel. This potential hazard was identified in the first round by a panel member who stated that a nurse can be "assertive but perceived as aggressive" (6) and whose manner and appearance "sets the tone for the interaction" (02). Considering how a nurse and health service presents themselves to the community may provide opportunity to improve communication and relationships, building trust and subsequently reducing the risk of violence.

Stress and fatigue were also considered to contribute significantly to the risk of violence by the panel. RANs experience high levels of distress related to a lack of infrastructure and the high acuity of their patients (Ellis & Kelly, 2005). RANs take less sick days as there is no-one else to cover for them and work 2 days more per week than their metropolitan counterparts (Lenthall, et al., 2011). Staff who are tired and under pressure may be less likely to recognise behaviours that may be the precursors to a violent incident and they may not be able to employ the patience, calmness and communication skills needed to diffuse an aggressive situation (Ferns, et al., 2005). Lenthall et al. (2009) claimed that workplace violence is contributing to high staff turnover and exposure to violence in small communities puts RANs at risk of developing Post Traumatic Stress Disorder (PTSD).

Panel responses to the hazard rating of 'Prior experience with violence' was polarised and this fits with the idea that some people become more confident or desensitised to

the effects of violence over time, where some people may become over sensitised especially if experiencing PTSD (personal communication, S.Lenthall, 15/10/10).

Fisher, et al, (1996) hypothesised that single women are more at risk of experiencing violence in the remote setting as they “lack the ‘protection’ that husbands provide” (p.197). The experts in this study lacked agreement and consider being a single woman to either not be factor that increases the risk or to be a moderate increase in risk. It is not known what impact marital status or gender has on the incidence of violence towards RANs. Further analysis using data from the “back from the edge” project (Opie, et al., 2010), may reveal a correlation between self reported incidence of violence and demographic details of the respondents.

Client

Hazards specific to the risk of violence from users of the health service were identified as; clinical presentation, stress, communication and service expectations.

Clinical presentation

The panel agreed that intoxication with alcohol, petrol sniffers and to a lesser extent marijuana was the most significant risk factor to consider during a violence risk assessment. Intoxicated individuals may stumble, project anti-social behaviour, overact, be more easily offended, quick to blame, display decreased inhibitions, be more sexually overt, disregard consequences and have difficulty processing complex information (Ferns, et al., 2005). The panel also recognised that a client who was showing signs of irritability or suspiciousness or appeared to be displaying impulsive behaviour or lack of respect, was a greater risk to a RANs personal safety. This is supported by the literature (Mayhew, 2000), specifically, Sands identifies 10 risk factors for violence "history of aggression, male, youth, antisocial traits, substance misuse, intoxication, impulsivity, irritability, suspiciousness and mental illness"(Sands, 2007p.108).

Clients with a history of violence were identified by the panel as the second most significant hazard that increases the risk of violence, however, the panel only showed moderate support for documenting clients with a history of violence even though this is highly significant in terms of risk assessment (Luck, Jackson, & Usher, 2007; Sands, 2007). The third round of this study provided further clarification and showed that panel members were concerned with labelling clients as violent which may adversely affect their care in the future or violate their right to privacy. It appeared from the panel's descriptions that this information was rarely passed on and that there was no standardised way of documenting or handing over this information to other health professionals. The client's right to privacy was contested by one panel member who felt that staff safety was more important and that someone who had committed an act of violence did not deserve to have their privacy if it put staff at risk (13).

Mental illness was identified by the panel as a significant hazard with the qualifier that intoxication and non-compliance with treatment regime further increased the risk. Suicide, substance abuse, psychoses and depression are common in Aboriginal communities (Morgan, 2006). Access to mental health services is limited due to isolation, cultural and language barriers and often complicated by substance abuse. However, it has been suggested that a patient who is compliant with treatment, has good insight into his/her disorder, has a good rapport with staff and good social networks has a lower risk of violence (Doyle & Dolan, 2002).

According to the panel's responses, gender appears to be a low indicator of risk. This is contrary to the literature which identifies that men are more likely to be the perpetrators of violence (Barling, Dupré, & Kelloway, 2009; Sands, 2007). Fisher et al's (1996), study showed that in terms of violence towards RANs, the offenders were most likely to be male, Aboriginal and a client or his relative. Other physical characteristics of the client such as a greater size or strength or who had a 'rough' appearance were not considered reliable indicators of risk by the panel.

Property damage also seemed to be a reasonable indicator of increased risk, however, one panel member commented that Aboriginal people seem to have a different view of the value of property and may not consider damage to be 'violence' (08).

Clinical presentation of the client was identified as a minor risk by the panel. There are many medical conditions that may contribute to a client becoming aggressive and these include: alcohol withdrawal/ acute intoxication, hypoglycaemia (Queensland Health and Royal Flying Doctor Service, 2009); psychosis, confusion, brain injuries or drug use (including prescription medicines) (Central Australian Rural Practitioners Association, 2009). It is possible that the panel feel less threatened by a client displaying violent behaviour if it can be explained by a medical condition, particularly if that condition is transient.

There was difference in opinion over the level of risk posed by an unknown client, with the responses covering the whole range from 'not a hazard' to 'extreme hazard'. This may reflect differences between the communities represented by the panel as some have a more transient population than others. In addition, the non-consensus of the panel may reflect the individual panel member's knowledge of their own community. Some panel members travel between communities and as a result encounter unknown clients frequently. 'Out of character behaviour' was seen as a moderate indicator of risk by the panel, this behaviour has been described as a sign that something wasn't right and could indicate that extra caution is needed, but relies on knowledge of the patient by the health professional (Murphy, 2004).

Stress

The panel agreed that previous bad experiences with the health service may increase the level of stress for a client. The stress on family members who accompany the client and may be expected to make decisions and take responsibility was also identified by the panel. The socio-economic status and difficult life situations that many remote indigenous people experience was identified by the panel as a moderate hazard that increased stress on clients seeking healthcare from RANs. People accessing a health

service may be under considerable stress for a variety of reasons. Chaplin and Alison (1998) identify factors such as pain, tiredness and frustration at restrictions imposed because of a medical condition that may cause a patient to be less tolerant of interventions. Fisher, et al.,(1996) also identify grieving or sadness as stressors.

Communication

The panel rate language difference as only a minor to moderate hazard and this is contrary to the literature which suggests that communication difficulties can be significant, particularly in indigenous communities where English is not the first language and may be a considerable stressor (Trudgeon, 2000). The panel are all experienced RANs, so perhaps they have highly developed communication skills, have learned the local language or make use of available resources such as AHW's or interpreters. Further research that investigates communication between RANs and Indigenous clients, who do not have English as a first language may help clarify this issue.

Service expectations

The panel reached consensus by rating "different service expectations" as a moderate hazard, and stating that a refusal to treat minor ailments after hours was "taken badly" (13). Differences between the nurse and the client in terms of health concept and priority was identified as a moderate but "very common" (13) situation. Denial of service or providing a service that does not meet the expectations of the client is recognised as a trigger for violent incidents (Magin, et al., 2005; Mayhew, 2000; Northern Territory Government, 2009) In addition, lack of understanding of the role of RAN, along with dissatisfaction with the service provided and unreasonable or illegal requests were identified as factors that may have contributed to violent events (Fisher, et al., 1996).

Overall, the panel have indicated that the client is a lesser contributor to violent incidents when compared to the contribution of the nurse, environment and organisation. This is shown by the much less frequent choice of major or extreme hazard when completing the questions related to the client. It may also reflect an inability to change the risks presented by a client. People are unpredictable and characteristics identified in this study may be present in certain people under certain circumstances and this may change at any time. For example, a person with a history of violence when under the influence of alcohol, may at other times be a calming and supportive influence in the community.

Organisation

The organisation within which RANs work is considered as not just the employer but also the broader community context. The panel identified a number of hazards that included the organisational culture, policies and procedures, recruitment and retention of staff and community collaboration.

Organisational culture

A new theme emerged from the second round that encompasses the culture of the organisation and the way it deals with violence. A culture of acceptance that verbal abuse is 'part of the job' contributes to the risk of violence in that it encourages the 'context of silence' that surrounds violence in the remote area nursing workplace (Fisher, et al., 1996). Adopting an attitude that verbal aggression does not affect the RAN personally, may appear to be protective for some RANs but it may also discourage reporting and discussion amongst RANs about the effects of verbal aggression, as doing so may be seen as 'weak'. Under-reporting of violent incidents is recognised as a hazard by the panel and well documented in the literature (Ferns, 2006; Fisher, et al., 1996; Luck, et al., 2006).

Lack of action from management was identified as a very significant hazard by the panel and part of the culture of some organisations (Jones & Lyneham, 2001)**.** Considerable frustration was noted from some of the panel's responses, particularly when hazards had been identified which management did nothing about. An example was given of a formal security audit that was conducted on one panel member's clinic and two years later none of the recommendations had been actioned. One of the reasons cited for the under-reporting of violent incidents is the belief that nothing will be done about it anyway (Ferns, 2006). Lack of action is also related to a lack of understanding and acknowledgement of the problem of occupational violence by management. This lack of acknowledgement is also evidenced by an apparent lack of honesty about the level of violence within particular communities (03,06).

Policy and procedures

The panel considered the inadequacy of policies and procedures to be a moderate hazard. However, supporting staff safety should be a high priority and every organisation should have policies and procedures in place for dealing with and reporting on the issue of occupational violence (Armstrong, 2006; Wilkinson & Huntington, 2004). Collecting data on violent incidents allows practice reviews and improvements to occur (Chaplin & Allison, 1998). According to Hegney et al. (2003), policies and procedures are less likely to be in place in rural and remote areas and where they are in place, they are likely to be inadequate and inaccessible. A wide

ranging review of policies and procedures by various employers, including non-government organisations, was not possible in this study due to time and resource constraints. However, a review of the 'managing aggressive incidents' policy of the Northern Territory Department of Health and Families (Northern Territory Government, 2006) identifies the use of duress alarms monitored by an outside agency with contact details checked monthly, zero tolerance to violence towards staff, diffusing the situation early and leaving the situation (including the community if necessary) as main features of its policy. This policy emphasises attending after-hours consults in the clinic rather than outside in the community and also highlights the importance of building relationships within the community and identifying people who may be of assistance in a potentially violent situation.

The panel considered communities without a police presence and single nurse posts to have a greater risk of violence. A minimum of three staff at each clinic including Aboriginal Health Workers and General Practitioners was the level considered safe by the panel. There was a mixed response to the issue of working alone after hours and this may be a reflection of the likelihood of this occurring or it may indicate that this aspect of autonomous RAN practice is rewarding and the risk outweighs the benefits. Single nurse posts are not supported by CRANA*plus* or the Australian Nursing Federation (Lenthall, et al., 2011)

Panel response to the level of risk posed by patient transport was mixed and may reflect the likelihood of that role being undertaken with an aggressive patient, for example, if an aggressive patient needed to be transported for further medical management either by road or air there are policies and procedures in place for this situation (Central Australian Rural Practitioners Association, 2009; Queensland Health and Royal Flying Doctor Service, 2009). However, transporting clients can be hazardous and needs to be assessed carefully (Northern Territory Government, 2009). Keeping vehicles well maintained (Skillen, et al., 2003), as well as avoiding transporting a single client and ensuring a responsible person travels with a potentially aggressive client are two suggestions for decreasing the risk to the driver and passengers (Northern Territory Government, 2009).

Recruitment and retention

High staff turnover was recognised by the panel as a major risk to the safety of RANs. High staff turnover and inadequate numbers and skill mix of staff in communities is a significant stressor for RANs (Lenthall, et al., 2009). This stress is proportional to increased workload, supervision and fatigue from constantly orientating new staff to the community. As previously mentioned, workplace violence has been cited as a major

factor in staff turnover (Jackson, et al., 2002; Lenthall, et al., 2009). The recruitment of adequately prepared and experienced RANs should be a priority.

Retention of RANs using a variety of strategies including personal and professional support appears to be a priority if a reduction in violence is to be realised. However, it is not known if experienced RANs actually experience less violence. Further research regarding retention strategies and violence reduction strategies may provide insight and direction for improvement in the length of service of RANs

Community collaboration

The panel recognised that RANs are on-call in times of community stress and disorder and this carries an increased risk of violence towards RANs. As stated by one panel member, “the clinic staff are always present, have access to phones, speak English and can communicate with authorities - they nearly always end up being the people to go to for any crisis” (02). Fisher et al.’s seminal work (1996), suggested that violence reduction strategies should focus on involvement with the community and this idea was strongly supported by the panel. Providing a forum to encourage dialogue such as a safety committee or meetings with community leaders should be encouraged. Developing a mutual understanding of service expectations should be one of the aims of a formal consultation practice as denial of service and a difference in priority between the nurse and the client was identified by the panel and the literature as a trigger for violent incidents. Consequences for violent offenders would need to be considered and implemented by the community. The panel also felt that the control of dogs should also be discussed with the community. This is a common hazard for RANs with many suffering bites in the course of their employment (personal communication, CRANA*plus* conference, 16/10/10).

Control measures

Control measures are programs or tools that are developed in response to the identification of hazards and aim to eliminate or reduce the risk posed by the identified hazards. A toolbox of ideas is suggested in recognition of the complex nature of violence in the workplace.

Hazard identification checklist

In round one, the panel were asked to comment on the usefulness of a checklist to aid in identifying environmental hazards in the workplace. A tool of this nature was supported particularly for use by new staff. However, the use of checklists was seen as increasing the workload of already overworked staff, and likely to be ineffective, if the hazards identified were not rectified or “actioned” by management. This viewpoint is important to consider when developing control measures as the support of both management and staff on the ground is vital to the success of new tools, procedures or programs.

Education and training

Education and training in assessment of risk using the behavioural precursors of violence did not reach the required level of consensus amongst the panel indicating an opinion that these skills have minimal value in reducing the risk of violence towards RANs. This is contrary to the literature, which suggests that violence risk assessment is more accurate when approached in a structured manner (Sands, Gerdtz, & Elsom, 2009). It is possible that the panel members were not clear on what was meant by the term ‘behavioural precursors’ used in the questionnaire, or perhaps the panel felt ‘on the job’ education was more valuable than structured education. Violence Risk Assessment tools have been developed, particularly in the area of mental health (Abderhalden et al., 2004). These tools usually consist of a checklist of objective and subjective observations, in varying amounts of detail, that allow the Health Professional to make judgements on the likelihood of violence in that instance. These tools are most often used in an inpatient setting and focus is often about protecting the public rather than health workers. Recently, tools designed for use in the emergency department, specifically with a focus on violence assessment at the point of triage, have been developed (Luck, et al., 2007; Sands, 2007; Sands, et al., 2009). Psychometric testing or an evaluation of the implementation of these tools is unavailable. A study to review the use and effectiveness of a Violence Assessment Tool in an acute care hospital found that a simple flag system attached to patient files was reasonably effective in alerting staff to patients with the propensity for violence (Kling et al., 2006). This indicates the value in developing an assessment tool to identify potentially violent

clients. Development of an instrument to measure the potential for aggression in any situation could guide RANs in implementing extra precautions and requesting an escort to high risk call-outs. However, it is not known if a tool of this nature would be acceptable to RANs or appropriate for use in remote health services.

The development of ‘gut feeling’ is partially based on a sub-conscious recognition of these pre-cursor behaviours and underdeveloped instinctive responses ranked fourth highest for hazardous nurse characteristics. Despite lack of agreement over the usefulness of education about violence risk assessment, the panel rated de-escalation techniques highly, and knowing when to employ these techniques is vital to their success. When properly trained the nurse can use techniques to diffuse a situation and in turn, limit the duration and extent of a violent incident (Viitasara & Menckel, 2002; Wand & Coulson, 2006). De-escalation techniques include: apologising without accepting blame, not making excuses or arguing, listen and say nothing or asked questions if needed, all in a calm and respectful manner (National Health and Medical Research Council, 2002). De-escalation techniques such as empathy, clear communication skills, remaining calm and displaying respect (Luck, et al., 2007; Wright, et al., 2003) as well as instructing nurses that they must remove themselves from situations that are deteriorating, do not attempt to disarm, do not argue, threaten, or block the exits of an aggressor (Williams and Robertson, 1997 as cited in Ferns, 2005).

Training has been shown to prevent violence (Farrell & Cubit, 2005). A nurse who is not equipped with the skills needed to assess a situation and apply strategies to decrease the extent and impact of that aggression contributes to the hazard. The provision of accessible and acceptable training in aggression management aims to empower the nurse to control and diffuse an aggressive situation. Attendance at education sessions is particularly difficult for RANs due to the costs and time of travelling and the difficulty getting relief staff (Senate Community Affairs References Committee, 2002). Online resources are now available (Council Remote Area Nurses Australia, 2010b). Cultural safety education programs were also very well supported by the panel. Education to recognise the symptoms of Post Traumatic Stress Disorder in themselves and others and was supported by the panel as it may help minimise the effects of violent incidents. Additional training for RANs should include: how to engage community support and participation in violence reduction strategies such as safety plans, clinical management plans and community education programs as well as mental health assessment.

Professional support

The panel agreed that providing professional support was an essential strategy in reducing the risk of violence. Professional and personal support is the most valued retention initiative by health workers according to a review of the literature by Dolea et al. (2010). Current professional support for RANs comes from the CRANA*plus* supported Bush Support Services (Council Remote Area Nurses Australia, 2010a) and includes a telephone and internet counselling service, education program, and resources including links to other support services through their website. Panel support for this program was unanimous and may assist individuals with establishing boundaries between private and professional lives of remote health staff which can be difficult (Bourke, et al., 2004; Morgan, 2006). Identifying support networks is an important step in promoting self care (Morgan, 2006). Chaplin and Alison (1998) highlight the importance of seeking support and debriefing to help deal with the potential for Post Traumatic Stress Disorder after experiencing a violent incident at work. Post violence support was mostly provided by co-workers in an Australian Teaching Hospital (O'Connell, et al., 2000) “Acknowledgement of RANs as victims of a blame-free traumatic event is of crucial importance in the development of policies and intervention programs to address the issue of personal safety of RANs” (Fisher, et al., 1996,p.198).

A mentoring program was suggested and supported by the panel as long as it was formally recognised and resourced. Mentoring may be described as a relationship between two people that exists to provide support, personal growth and an increase in professional role effectiveness (Waters, Clarke, Ingall, & Dean-Jones, 2003). It is characterised by core qualities of confidentiality, honesty, sharing of information, enthusiasm and a commitment to an ongoing relationship (Waters, et al., 2003). Suggested methods for establishing a program in remote areas include an initial training workshop, establishment of a Mentor Register and encouragement in the use of technologies such as email, web-based discussion forums and regular telephone contact.

The panel felt that a comprehensive orientation program was vital to safe practice. The model developed for GP registrars in the Northern Territory has a strong focus on cultural safety and self care. The authors claim that the model has applicability across disciplines and is particularly useful for RANs (Morgan, 2006). Orientation to Remote Aboriginal communities is designed specifically for each registrar, and includes a community visit and introductions to relevant community members to gain informed consent for the placement. The model provides training in communication skills and relevant language; a tiered cultural safety program that develops in complexity

throughout the employment of the registrar; comprehensive mental health clinical skills and a formal discussion with the trainer regarding self care issues including professional and personal support networks. Providing orientation to the specific community new staff are to be employed in recognises the need to quickly gain knowledge about the culture of that community. Currently around 30% of staff receive no formal orientation and of those that did, around 50% considered it to be inadequate (Rickard, 2010). As a form of on-going orientation and support this program would aid the new RAN to gain the knowledge and skills considered protective against violence. It could also aid in the retention of 'corporate knowledge' that is frequently lost due to the high staff turnover and aging nature of the RAN workforce (Rickard, 2010).

Attempts to reduce work related stress, including maintaining adequate staffing levels and evidenced by employers becoming involved in "employer of choice" programs, are strategies endorsed by the panel. Inclusion of individual assessment of culturally appropriate behaviour as part of an employee's annual performance appraisal received moderate support from the panel.

Organisational responsibilities

Panel members saw action from management as a priority when considering violence in the workplace. They want management to do something about the hazards they are reporting. Essentially, the panel feel there is talk about this issue but no real evidence of action (03).

Maintaining adequate numbers of police and nurses was identified by the panel as an important strategy in reducing the risk of violence. Also having a paid escort or "2nd on call", for after hours call outs was strongly supported by the panel. Taking an escort was also identified by (Fazzone, Barloon, McConnell, & Chitty, 2000) as a strategy to reduce risk. Participants in their study recognised that while it may make the staff member feel safer, there were serious issues of company liability and patient confidentiality to consider.

Other practical strategies endorsed by the panel include a process for updating community contact lists, establishment of a check-in system if working alone, a management plan for drug seekers and a process for documenting clients with a history of violence.

Policy and procedures

Policies and procedures were seen by the panel as important organisational responsibilities, however a perceived lack of RAN involvement, inflexibility and lack of evaluation of policies and procedures contributed to the belief that they were more about protecting management than the staff on the ground. 'Zero tolerance to violence'

policies were well supported by the panel as a strategy to decrease the incidence of violence, however, the practical implementation of these policies, including consequences for violent behaviour were seen as problematic. The term ‘zero tolerance’ is commonly referred to in literature related to violence in the health setting as a strategy to reduce occupational violence (Ferns, et al., 2005; C. Holmes, 2006; Middleby-Clements & Grenyer, 2007; National Health and Medical Research Council, 2002; Northern Territory Government, 2006). Evidence to support the use of this strategy to decrease the incidence of violence is non-existent (C. Holmes, 2006). However, having policies and procedures in place regarding occupational violence are seen to be protective (Nachreiner, et al., 2005). It has been argued that Zero tolerance policies inflict harsh penalties without consideration of the circumstances or motivation of the offender, nor do they allow for professional judgement (C. Holmes, 2006).This policy was advocated in a report by the National Health and Medical Research Council (2002) for use in remote areas but no description of its practical application was given. It is also used in other Australian state healthcare policies (Middleby-Clements & Grenyer, 2007; Northern Territory Government, 2006) as a strategy for decreasing the incidence of violence in healthcare situations. The panel identified that there are serious ethical concerns with this strategy particularly in regards to duty of care when the patients have no other option for seeking medical assistance (08,06) and it can affect the quality of the relationship between staff and clients. However, having a ‘zero tolerance to violence’ policy may give some reassurance to staff that the problem is recognised by management and will be taken seriously. Other policies suggested by and supported by the panel were: critical incident policies and procedures, policy stating that a nurse is not to attend an intoxicated client without the presence of a sober, reliable person; nor attend to clients in the nurses home.

The panel identified that policies were of little use if they weren’t backed up with consequences for breaching those policies. Reporting the incident to management or police was suggested but there was concern that the victim would not receive adequate support from either party to prosecute the offender. Enforcement of these policies was also hampered by a lack of police and community support, due at least in part to concern of ‘payback’ or retaliation from the offender or their family towards the enforcer.

Community collaboration

The panel showed overwhelming support for community involvement as a strategy to address the issue of violence. Involving community members in the planning and implementation of strategies along with the orientation of new staff to the community were seen as very useful or essential. The results of this study, when considered in the

broader paradigm of service provision in the Primary Health Care context, point to the importance of community control of their health service. The key principles of Primary Health Care include; community participation, accountability between the community and health service and a holistic approach to health care (Eckermann, et al., 2010). Negotiating service expectations with the community, community participation in the recruitment, orientation and training of staff as well as policy and procedure development; along with addressing the wider issue of violence in their community may be the most effective tools in reducing violence towards RANs. The Primary Health Care process is about control and not just consultation (Eckermann, et al., 2010) and in this process the community get the health service that is most acceptable to them. It stands to reason that a service that is valued by a community, and the staff have been chosen and trained by them may experience less violence and more success in achieving improved health outcomes for that community. It is not known if nurses working with community controlled health services experience less violence than their government employed counterparts. In addition, it is not known if the overall level of violence within a community is directly related to the frequency or severity of violence experienced by RANs within that community. Dealing with community violence may have the added bonus of improving the safety of staff within the community. Further research with a focus on the perspective of the community towards their health service and their experience of violence may reveal a new path towards reducing violence towards RANs.

Development and implementation of a community specific safety plan was well supported by the panel. Developing a local plan in consultation with the community and identifying local resources feature heavily in the recommendations of the National Health and Medical Research Council (2002). Building relationships with local councils, night patrols and the police may provide opportunities to discuss local issues and develop strategies to improve the safety of the whole community as well as detailed plans to deal with violent incidents. The Australian Institute of Criminology, client initiated violence handbook (Mayhew, 2000) identifies that in some communities certain days may see more violent behaviour. For example, pay days, and more resources may need to be employed on those days.

In the third round, the panel were asked to describe the essential components and barriers to a safety plan. In essence a safety plan should include what to do in the event of an incident; who to call and when as well as how to get to a safe place if needed. An additional component of a safety plan is detailed guidelines for behaviour in specific places or events and procedures designed to reduce the risk of violence. Another essential aspect of a safety plan is the involvement of the community as a

whole. This process aids in community acceptance of the plan which is vital to its success. Barriers identified by the panel included the amount of time and effort it would take and the lack of resources in which to do it.

Violence management toolbox

The risk of violence towards RANs cannot be completely eliminated as their job involves intimate interactions with individuals and the community. Therefore, strategies to improve the personal safety of RANs must be aimed at minimising the incidence, duration and severity of violent incidents (Grammeno, 2009; Viitasara & Menckel, 2002). According to Viitasara and Menkel (2002); Primary prevention strategies are applied in everyday practice, Secondary strategies are used when an aggressive or violent incident occurs and Tertiary prevention strategies aim to prevent a recurrence of the event and minimise any on-going distress to staff as a result of a violent incident. Figure 11, summarises the suggested control measures which have been discussed and places them in the context of their role in preventing violence towards RANs. The concept of a 'toolbox' recognises that there is no single solution to a complex problem like occupational violence and that a variety of tools should be offered that can be adapted to different situations by nurses with a range of skills and experience.

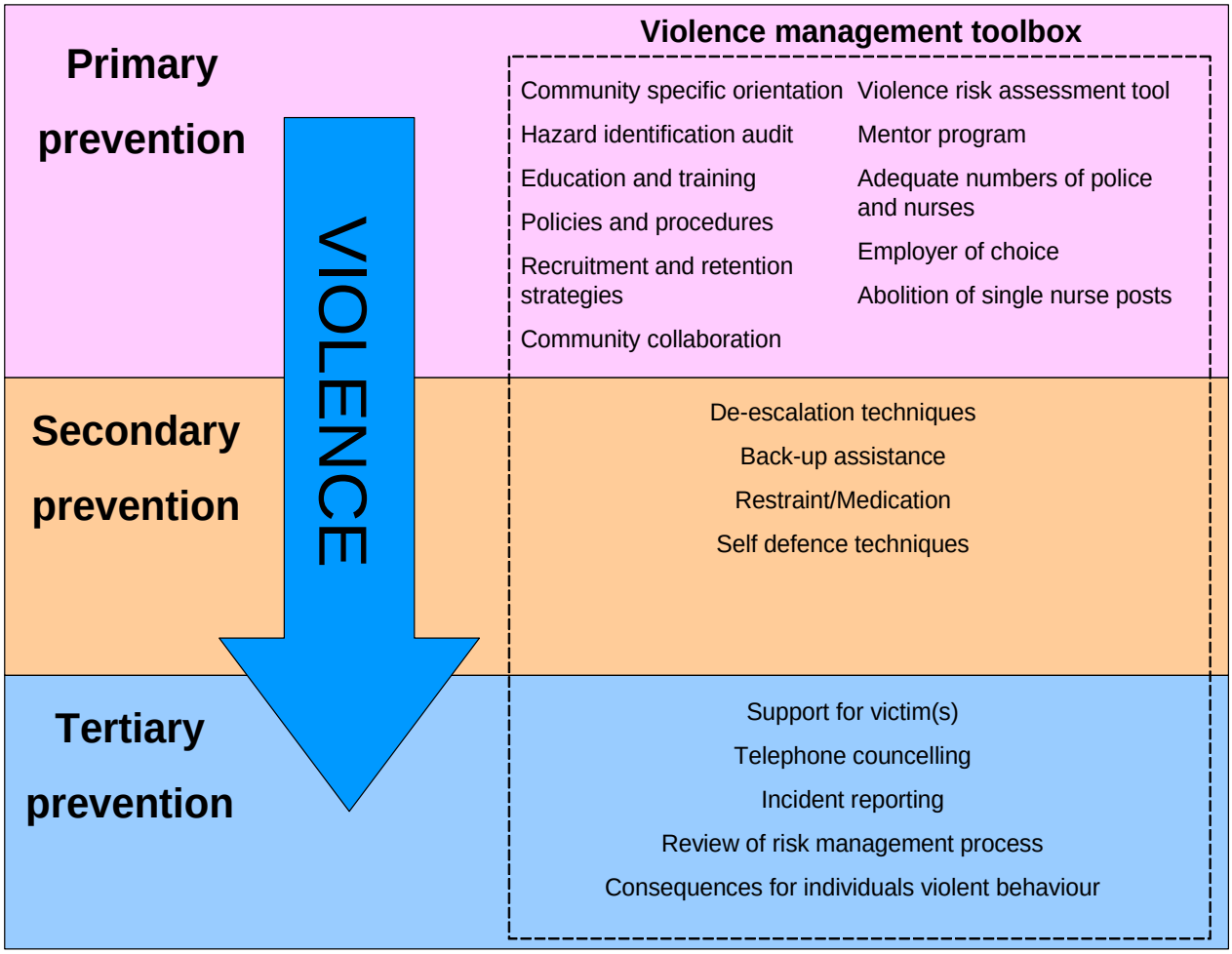

Figure 11 Violence management toolbox

Further development of the measures described in the 'violence management toolbox' above will be required before implementation and evaluation of these measures can

take place. If the issue of violence towards RANs is considered as a social construct then the need for an holistic approach considering the many factors that contribute to violent incidents is evident. Adopting a ‘toolbox’ strategy has the potential to radically improve the safety of RANs.

Limitations to the study

Caution will be needed when generalising results from the study due to the small sample size and limited geographical representation. However, all of the major geographical regions are represented and the experts were chosen in part for their knowledge of the broader experiences of RANs. The variety in size of population represented within the sample indicates that the results can be applied across small and large communities. It is unfortunate that the views of Aboriginal or Torres Straight Islanders are not represented, particularly as this research relates to largely indigenous communities and a greater understanding of the cross-cultural issues may have been achieved. As this research relied on the knowledge of experienced RANs, the views and experiences of nurses new to this area are not included in the results. This could be significant and may need to be considered in further research.

Results may reflect opinion and not reality and may represent collective ignorance (Adler & Ziglio, 1996). For example, a bias towards panel members who resided in the same geographical area may generate data only relevant to that area as they may collectively be unaware of issues relevant to other areas. Consensus amongst the panel was not always reached. However, exploration and consideration of those differences revealed important data (Beretta, 1996; Vernon, 2009).

The quantity and quality of the data provided varied considerably with some participants contributing a page per question and others a few lines. The need to write answers to open-ended questions may have limited the contribution of some respondents due to time constraints. Group discussion may have stimulated other ideas. Time constraints also limited this study and this prevented satisfactory development of all ideas at this stage. However, these issues will be highlighted as areas for further research. Attrition and fatigue of panel members affected response rates which in turn affects validity (Beretta, 1996). The final round saw a marked drop in number of participants (n=5). Despite keeping the questionnaires within the planned 30 minute completion time, the poor response to the final round may indicate that the questions were becoming more complex and required specific knowledge not held by all the respondents.

Recommendations

This study has suggested a number of recommendations for research, education and management that deserve further investigation, as outlined below.

Research

- Further research to consider correlations between demographic variables such as years of service, employer type, gender, marital status and incidence of violence to identify nurses most at risk.
- Consultation with community leaders regarding service expectations and consequences for violent behaviour.
- Greater understanding of the 'context of silence' and work culture that promotes verbal abuse as 'part of the job'.
- Implementation and evaluation of the violence management toolbox including:

  Psychometric assessment of tools

  Implementation and evaluation of education programs

  Implementation and evaluation of orientation/ mentor programs

Education

- Assessment and evaluation of Cultural Safety education programs.
- Assessment and evaluation of Aggression management programs.

Management

- Assessment and auditing of safety of health service environments. Development of Remote Health Service audit tool.
- Review and analysis of remote organisations policies and procedures
- Development of policies and procedures with direct RAN involvement.
- Greater community control of health services.

Conclusions

Remote Area Nursing practice is characterised by living and working in isolated communities with complex health needs. The incidence of violence towards RANs seems to have increased over the last 13 years (Opie, et al., 2010) with violence identified as a significant stressor for RANs, contributing to high staff turnover (Lenthall, et al., 2009). This study adds to the understanding of why that apparent increase has occurred and provides suggestions for consideration to halt the increase in violence.

This study sought to document the views and opinions of a panel of expert RANs in order to identify hazards that contribute to an increased risk of violence in their workplace and to collate and develop their ideas for strategies to reduce the risk of violence towards RANs. Documentation and analysis of the knowledge and insights of RANs in regards to this phenomenon has not previously been conducted and as a result, this study adds to the body of knowledge relating to Remote Area Nursing. The use of a risk management framework in this context has been suggested, however, a panel of experts has not previously been involved. The use of the Delphi technique via the internet, as a research method, allowed access to a population not often researched, due in part to its vast geographical spread.

The results from this study have revealed that RANs practice in a wide variety of environments and experience high levels of stress in their work, complicated by living in a remote area and caring for communities with high health needs. The panel also identified that the culture of the employing organisation and the community played a significant role in the prevention and management of violence.

The working environment was a significant component to the risk of violence. Building design that did not provide a safe room or multiple exits from the building and inadequate security features, such as lighting, alarms or locks, increased the risk to RANs. Recognition of the requirement for RANs to attend to clients outside the relative safety of the clinic building enabled hazards specific to RAN practice to be identified. Attending call-outs without the back-up support of colleagues or police and without suitable communication devices or a check-in system exposed RANs to additional risk. It was noted that clients at times came to the RANs private residence and that this created a situation of risk specific to RAN practice. Assessment of the work environment either by the nurses themselves, with training and support or an independent assessor should be considered a priority by employers.

The level of experience as a RAN was considered by the panel, to be related to the risk of violence, with inexperienced nurses (less than four years as a RAN) perceived to be at greater risk. Specific preparation for the role of a RAN included cultural safety and

self- awareness, aggression management and communication skills. The recruitment and preparation of skilled staff with on-going support and reduction of the causes of stress were aspects of a risk reduction strategy that should be adopted by employers. Provision of professional support services such as the Bush Crisis Line should continue and additional programs such as mentoring and education should be considered.

The effect of alcohol, drug abuse and mental illness on the risk of violence posed by a client, as described in the literature, was confirmed by the panel. In addition, consideration of the stress being experienced by the client either from their life situation, the act of attending a health service or simply being unwell were further factors that increased risk. Difficulty with communication or differences in service expectations also contributed to violent incidents.

Action from management when hazards are identified and evidence of a commitment to violence prevention initiatives were seen as organisational responsibilities. Involvement of RANs in the development of policies and procedures along with recognition of a need for flexibility and regular evaluation could provide additional support and guidance for RANs. Encouraging the reporting of violent incidents and challenging the work culture that accepts violence as ‘part of the job’ will go some way to diminishing the “context of silence” (Fisher, et al., 1996) that exists around violence in the workplace.

This study suggests that greater effort in advancing the principles of Primary Health Care would encourage community involvement and responsibility in regards to violence. Ultimately this could reduce the risk for RANs by improving communication, developing trust and respect among all parties. Creation of a community specific safety plan that included consequences for violent behaviour should be considered. Such a plan requires consultation and commitment from the community and be adequately resourced and supported.

This thesis forms a basis for further research into the issue of violence towards RANs. It advises managers and policy makers as to the hazardous nature of remote area nursing and suggests strategies to improving the safety of RANs. The study findings may provide nurses with information to better inform themselves as to the risks in their workplace. The study is likely to be relevant to other remote health professionals including doctors and aboriginal health workers in Australia and overseas. There may also be some benefit to other professions such as teachers who may share some of the job characteristics such as lack of professional or personal support when working in remote areas.

This study proposes a toolbox strategy to decrease the risk of violence towards RANs. Further research and development of the control measures outlined in this study is required. Additional consultation with RANs and remote communities could add to the understanding of the role of ‘experience’ described in this thesis.

Publication of the results of this thesis may stimulate discussion and action from management and RANs to reduce the notable rise in violence towards RANs.

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Appendix A: Information letter for participants

Violence towards Remote Area Nurses: A Delphi study to develop a risk management approach.

You are invited to participate in this project, as a member of an expert panel; which is being conducted as part of the requirements of an Honours degree. Participation in this project is voluntary. If you choose to participate, you are free to withdraw from further participation at any time without giving a reason and with no negative consequences.

Details about the research are given below:

Student name: Kylie McCullough

Award*:* Bachelor of Science (Nursing) Honours

Supervisor: Associate Professor Anne Williams, Edith Cowan University;

Co-supervisor: Sue Lenthall, Senior Lecturer, Centre for Remote Health, Flinders

Institution*:* School of Nursing, Midwifery and Postgraduate Medicine; Edith Cowan University, Perth

Researcher Contact details: kmccullo@our.ecu.edu.au

Research Ethics Officer: Tel: (+61 8) 6304 2170 Email: research.ethics@ecu.edu.au

The purpose of the project is to develop a comprehensive picture of the hazards commonly encountered by Remote Area Nurses that contribute to the incidence of violence in their workplace. Identification of hazards that require action and suggestions for the management of those hazards will also be collected.

The method of data collection (a Delphi study), requires the completion of 2 or 3 questionnaires, via email, within 7 days of receipt of each questionnaire. Each questionnaire will take approximately 30 minutes to complete.

Anonymity of participants is an essential component of this type of study to enable free expression of ideas. Your contact details, identity and any information that makes identification of your workplace likely, will remain anonymous to all but the researcher.

It is not anticipated that participation in this project will cause any discomfort. However, if any distress is caused you are encouraged to contact the Bush Crisis Line (free call: 1800 805 391 24 hours).

If you have any questions or require any further information about the research project, please contact:

Kylie McCullough

kmccullo@our.ecu.edu.au

Appendix B: Consent form

Violence towards Remote Area Nurses: A Delphi study to develop a risk management approach.

I have been provided with a copy of the Information Letter, explaining the project.

I have been given the opportunity to ask questions and any questions have been answered to my satisfaction.

I understand that participation in the research project will involve: Completion of 2 or 3 questionnaires.

I understand that the information provided will be kept confidential, will only be used for the purposes of this project and I will not be identified in any written documents or presentation of the results of this project. I understand that I am free to withdraw from further participation at any time, without explanation or penalty.

I freely agree to participate in the project

Name _____

Signature _____

Date _____

Appendix C: Letter of introduction

Dear Colleague,

I would like to introduce to you Kylie McCullough, an ex RAN (Remote Area Nurse) and current Honours research student at Edith Cowan University. Kylie is undertaking a research project to investigate what work practices, situations and aspects of Remote Area Nursing increase the likelihood of violence towards RANs, what the likelihood of these events occurring is and suggestions for control measures that may improve personal safety of RANs.

I have recommended you as a potential participant of an expert panel to develop these ideas. Participation involves completion of two or three questionnaires as part of a Delphi study.

Anonymity is a vital aspect of this study. If you choose to participate, information that may indicate the identity of participants or their health service will be coded and only Kylie will have access to e-mail addresses, and other identifying information. You are free to withdraw at any time without penalty.

If you are interested in participating in this study or you require more information please reply directly to Kylie on the e-mail address below.

kmccullo@our.ecu.edu.au

Many thanks,

Sue Lenthall

Project Manager

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Appendix D: Questionnaire Round 1

Thank you for agreeing to participate in this study. The views and experiences of those working in remote health are vital in the process of improving the safety of Remote Area Nurses. This is an interactive process, you will receive feedback regarding the groups responses.

The aim of this research is to understand what aspects of Remote Area Nursing carry a risk of violence. I am hoping to develop a tool to assist RANs with identifying situations of risk to their personal safety and then providing options for avoiding or minimising that risk.

Identifying the hazardous aspects of Remote Area Nursing practice allows the development of control measures that are specifically relevant to Remote Area Nursing. I need you to consider the broad questions of "*what is it about Remote Area Nursing that contributes to violent incidents?* And "*what can be done about it*?" while you answer the following specific questions.

This study is specifically about violence and Remote Area Nurses (RANs). This includes witnessing as well as experiencing; verbal aggression and obscene behaviour, property damage, physical violence, sexual harassment/abuse, telephone threats and stalking. It does not include bullying or violence between co-workers.

1) Hazard identification involves considering organisational structure and work practices; individual characteristics of nurse and the client; as well as the location they are in. Please list and describe hazards that contribute to the risk of violence for Remote area Nurses.

2) Considering the hazards identified above, what suggestions do you have for addressing them?

3) Making judgements about the level of risk a particular person poses is an essential skill for Remote Area Nurses. What knowledge is needed to develop this skill?

4) Hazard identification checklists have been developed in other industries, these checklists act as a prompt to check security of the work environment and surrounds. A checklist may include questions such as: *Does your clinic have a "safe room" with a phone and emergency contact details? Or; Are night-time access routes well lit and clear of vegetation etc that may provide concealment for would-be offenders?* Would a checklist be a useful tool for maintaining a safe work environment in remote health clinics? If so what kind of items would be on the checklist? If not, what other ways can staff identify problems with their work environment that may increase the risk of violence?

5) What other comments do you have about this topic?

6) The questions below will enable us to describe the Delphi panel.

What state or territory are you employed in?

Are you employed by a government organisation?

How many years have you been involved in Remote Health issues?

Are you currently employed as a RAN?

How many years have you worked as a RAN?

What is the population of your community?

Are you Male (M) or Female (F)?

Aboriginal/Torres Strait Islander?

Thank you for contributing your time and knowledge to this project.

Appendix E: Questionnaire Round 2

Hazard Identification

Many hazards were identified by the panel. Please indicate your level of agreement with each hazard as per the scale below. Remember you are indicating whether or not you agree that the item specified increases the risk of VIOLENCE for Remote Area Nurses.
Violence includes verbal abuse, physical assault, sexual assault, stalking and property damage.
At this stage we are not considering how likely a hazard is to occur but rather how much the hazard could contribute to the duration and extent of a violent incident.

1. Please write your name below. This just allows me to keep track of who has completed the survey and follow-up if there are any comments that need clarification. Your name is not available to anyone else.

2. In this question, we are trying to establish what aspects of the RAN work environment increase the risk of a violent incident occurring.

Environmental hazards	***Not a hazard***	***Minor hazard***	***Moderate hazard***	***Major hazard***	***Extreme hazard***
Unrestrained dogs					
Difficulty controlling bystanders (e.g.: excessive number of people incl: children, accompanying patient and nowhere for them to wait)					
Going to areas you don't know (e.g.: inaccurate maps or orientation to outstations, private homes)					
Not having access to a vehicle for attending call-outs at the clinic					
Alcohol outlet in a community					
Inability to securely lock the after hour consulting area					

Environmental hazards	***Not a hazard***	***Minor hazard***	***Moderate hazard***	***Major hazard***	***Extreme hazard***
Poor presentation of clinic (e.g. run down, graffiti)					
Inadequate external lighting (particularly over access routes and external utilities)					
Difficulty controlling who enters the premises after hours (e.g.: large number of keys, others using the building)					
No Call buzzers or duress alarms					
No formal safety plan (incl, who to call and what to do)					
Unable to conduct initial assessment of patient from a distance (e.g.: via phone/intercom or behind glass door/barrier)					
No designated safe room within the clinic (lockable with a phone)					
Unable to exit consulting room without passing the patient (consider positioning of furniture)					
Single entry/exit to the clinic					
Inadequate security of staff residences					
Attending to patients in your own home					
Other (please specify)					

3. In this question, we are trying to establish what characteristics of the nurse may increase their risk of experiencing a violent incident.

Nurse Characteristics	***Not a hazard***	***Minor hazard***	***Moderate hazard***	***Major hazard***	***Extreme hazard***
Being single					
Female					

Nurse Characteristics	***Not a hazard***	***Minor hazard***	***Moderate hazard***	***Major hazard***	***Extreme hazard***
Prior experience with violence					
Inexperience as a RAN					
Underdeveloped instinctive responses (gut feeling)					
Lack of common sense					
Unprofessional appearance					
Lack of clinical confidence					
Assertive manner					
Poorly developed communication skills					
Insufficient experience in assessment of mental health issues					
Lack of understanding of family and community structure and hierarchy					
Rigid personal belief systems					
Lack of awareness of specific indigenous culture and history of the community					
Experiencing the effects of ‘culture shock’					
Having a personal goal to “save”					
Forming ‘kinships’ with a particular group, (e.g.: joining a skin group)					
Merging personal and professional relationships					
Stress and burnout					
Tiredness and fatigue					

Nurse Characteristics	***Not a hazard***	***Minor hazard***	***Moderate hazard***	***Major hazard***	***Extreme hazard***
Motivated primarily by the financial rewards of Remote Area Nursing.					
Other (please specify)					

4. In this question we are trying to establish what characteristics of the client (either patient or other) may indicate the threat of violence in the remote setting.

Client characteristics	***Not a hazard***	***Minor hazard***	***Moderate hazard***	***Major hazard***	***Extreme hazard***
Intoxicated (alcohol or illegal drugs)					
Mental health issues					
Clinical presentation of the patient (e.g. dementia, head injury etc)					
History of violence					
Petrol sniffing					
Smoking marijuana					
Stress associated with ill health for both the patient and significant family members					
Difficult life situation					
Previous bad experiences with the health service (either personally or with friends/family)					
Differences in language between health staff and client					
Difference in health concept and priority with the nurse					

Client characteristics	***Not a hazard***	***Minor hazard***	***Moderate hazard***	***Major hazard***	***Extreme hazard***
Different expectations of service delivery (e.g.: inappropriate requests)					
Adult Male					
Adult Female					
Lack of respect towards nurses					
Damaging clinic property					
Patient not known to the health service					
Physical appearance e.g. “rough looking”					
Greater physical size/strength than nurse					
Patient displaying "Out of character” behaviour					
Displaying Impulsive behaviour					
Being irritable					
Acting Suspicious of the health service					
Non-compliance with treatment regime					
Other (please specify)					

5. Organisational characteristics
This question considers the role of management, government and the local community in increasing the risk of violent incident occurring. It also includes work practices and situations specific to remote area nursing.

Organisational characteristics	***Not a hazard***	***Minor hazard***	***Moderate hazard***	***Major hazard***	***Extreme hazard***
Inadequate Policy and procedures regarding aggression management of					

Organisational characteristics	***Not a hazard***	***Minor hazard***	***Moderate hazard***	***Major hazard***	***Extreme hazard***
the employing organisation					
Under-reporting of violent incidents by staff					
Lack of management follow-up of violent incidents					
Lack of understanding of the risk and effects of violence by management					
Work culture that tolerates verbal abuse as “part of the job”					
Working alone after hours					
Posts with less than three staff including nurses, health workers and medical officers					
Communities without a police presence					
High staff turnover					
Lack of honesty from management at recruitment about the level of violence in each community					
Nurses on-call during times of community stress and disorder					
Patient transport (incl, transporting patients to the clinic or for appointments)					
Other (please specify)					

6. Generally speaking, what is considered an "experienced" RAN?

	1 year	***2 years***	***4 years***	***10 years***	***15 years***
Years of employment as a RAN (more than)					
Any other definition of “experienced”					

Control Measures

1. This question is about coming up with recommendations in regard to the education and training needs to improve personal safety of Remote Area Nurses.

Education and Training	***Not useful***	***Useful***	***Very useful***	***Essential***
Identification of behavioural precursors to violence				
De-escalation techniques/ aggression management skills courses/ workshops				
Self-defence techniques				
Creating 'Clinical Management Plan' for patients with history of violence				
Behavioural effects of alcohol/drugs				
Engaging community support when providing care				
Assessment of the work environment for hazards				
Mental Health assessment				
Awareness of relevant indigenous cultural/ beliefs				
Awareness of own culture/beliefs				
Awareness of RAN culture				
Knowledge of the health service history and politics (Corporate knowledge)				
Understanding of power relationships that exist between the nurse, health service and the community				
Education regarding indicators of traumatic stress reactions (PTSD)				
Other (please specify)				

2. Please consider the items below in terms of their usefulness in improving the personal safety of RANs.

Professional support	***Not useful***	***Useful***	***Very useful***	***Essential***
Experienced RANs and AHWs providing community specific orientation				
Nationally standardised orientation program				
Formalised and rewarded mentor program for new RANs				
Performance appraisals that include assessment of culturally appropriate behaviour				
24hr access to Bush Crisis line				
Reducing work related stress				
Evidence of a commitment to adequate staffing levels of police and nurses				
acknowledgment of RAN as a victim of a blame free traumatic incident				
Employer aims to become an “employer of choice”				
Other (please specify)				

3. Please consider the statements below in terms of strategies that can be adopted by management or the community to improve the personal safety of RANs.

Organisational responsibilities	***Not useful***	***Useful***	***Very useful***	***Essential***
Paid on-call night driver positions and/or 2nd nurse on call				
Abolition of single nurse posts				
Police presence in all communities				
Regularly updated contact list				
Boundaries set for acceptable behaviour				
Consequences for violent behaviour				

Organisational responsibilities	***Not useful***	***Useful***	***Very useful***	***Essential***
Action from management in implementing strategies to reduce the risk				
Dis-incentive for patients accessing service after hours eg: financial				
Management plan for drug seekers				
Minimise need to attend call outs away from the clinic(patients find their own way)				
Pre-arranged distress message (e.g code word)				
Plan for management of nuisance phone/intercom calls				
Check-in system if working alone				
Formal debriefing process				
Recruitment of RANs based on specific selection criteria (not just taking anyone)				
Identification and documentation of clients with a history of violence (eg patient notes)				
Other (please specify)				

4. Please consider the statements below in terms of recommendations for inclusion in policies and procedures regarding aggression management.

Policies and procedures	***Not useful***	***Useful***	***Very useful***	***Essential***
RAN involvement in policy and procedure development				
Regular evaluation of policies and procedures				
Flexible policies that can be adapted to individual communities				
Policy stating that nurse never attends a client under the influence of alcohol/drugs without the presence of a reliable, sober person				
Critical incident management policies and procedures				

Policies and procedures	***Not useful***	***Useful***	***Very useful***	***Essential***
Policy stating that nurses Do not attend patients in their own home				
“Zero tolerance to violence” policy				
Other (please specify)				

5. Please consider the statements below as recommendations and rate the usefulness in improving the personal safety of RANs.

Community Involvement	***Not useful***	***Useful***	***Very useful***	***Essential***
Formal community consultation process established				
Development of mutual understanding of service expectations				
Collaboration in the development of a community safety plan				
Collaboration between health service/ community/ police in developing violence reduction strategies				
Community involvement in planning and implementing consequences for violent behaviour (eg: withdrawal of health services, conditions imposed on individuals)				
Involvement of community leaders in staff orientation				
Other (please specify)				

Thank you for completing this questionnaire. Your input is greatly appreciated.

Appendix F: Questionnaire Round 3

1. Please describe the essential components and barriers to creating a community specific safety plan. (eg: what should be included, how do you go about it, what could make it difficult to achieve? Have you been involved in creating a safety plan?)

2. References were made in previous rounds regarding the use of consequences towards individuals or the community for violent behaviour. What consequences are currently used, and for what behaviours? How is it implemented? What 'should' happen?

3. How is information about community members with a history of violence passed on from one health provider to another? Is it appropriate to 'flag' these individuals? If so, how? If not, why not?

Appendix G: Memo giving ethical approval for this study

EDITH COWAN UNIVERSITY

MEMO

FACULTY OF COMPUTING, HEALTH AND SCIENCE

Human Ethics Subcommittee

TO: Sharon Smart, Admin. Officer, Higher Degrees

FROM: Angus Stewart, Chair, Faculty Human Ethics Subcommittee

SUBJECT: Human Ethics Clearance Application/s

DATE: 25th June, 2010

Dear Sharon,

The following ethics application;

5364	Kylie	McCullough	Violence towards Remote Area Nurses: A Delphi study to develop a risk management approach

is cleared, category 1.

Data collection may commence immediately.

Best wishes,

Angus.

Appendix H: Researcher's experiences of violence towards RANs.

Bracketing exercise

This project had its genesis in the question " would you go out bush again?" My initial response was " no, it's too dangerous and I have children to care for now". In reality, the practicalities of my husband's work, adequate childcare and schooling are the greatest barriers to returning to working as a bush nurse but I found that feeling unsafe and at risk of assault evoked a feeling of fear so intense that I wouldn't even consider ways to overcome the practical obstacles.

I reflected some more on why I felt fearful about returning to a job that I truly enjoyed and felt challenged by. I did not experience any form of physical violence, nor was I personally threatened in my time as a RAN, or indeed in my life thus far. Verbal abuse such as swearing and yelling was directed at others or 'life' in general with one exception. An elderly lady with whom I had frequent and pleasant contact called me a "f*** White Rubbish Nurse" to my face when I refused to give her another bottle of eye drops (the 3rd that weekend) that she had lost. I felt surprised and a little upset but certainly not threatened by this incident. The only other incident that I can recall that involved me personally was when attending an intoxicated man with acute pancreatitis, from another community, who disappeared whilst I had my back turned during the consultation. The clinic was a 'rabbit warren' with many rooms and no way of properly securing the whole building. I was too afraid to search the dark building on my own so I asked a male friend to accompany me on the search. The man was eventually found by the police asleep under some nearby bushes with a clinic blanket keeping him warm.

So, if I wasn't ever personally threatened or assaulted, why did I feel so fearful? I think it was my vicarious exposure to violence. Patching up women victims of domestic violence and men involved in drunken fights was an everyday occurrence. The perpetrators often surprised me as I knew them to be ordinary people. I became wary of everyone, especially if they had been drinking, as I could see what they may be capable of. I also felt incredibly frustrated at my inability to do anything but treat the injuries. The greatest stress came after the violent deaths in bushland near my home of a mother and daughter, in separate incidents, by their respective husbands, 6 months apart. On both occasions the perpetrators contacted the nurse on call rather than the police to tell them what had happened. I think I took on some of the community's grief even though these women were not my personal friends or family. I saw the effect this had on other members of the community whom I did know, I saw the rapid rise in

alcohol consumption and related violence and I started to carry a ‘heaviness’ with me daily. I worried that my house was near the pub and locally referred to as the ‘nurses’ house and that people may come to me at home rather than the clinic. This was also because I had been there a long time and we went through a period of rapid change in staff. This high turnover also meant I didn’t have the support of the experienced staff that had supported me in the early days but I was supposed to reassure and support others.

Another incident occurred which is still very clear to me. That was the release from prison of a man, convicted of violent attacks who had threatened a nurse previously. That nurse, a colleague at the clinic, advised me of his release and her subsequent resignation from my community. She told me to be wary of him and never attend him alone or go to his outstation. I appreciated her warning but I became very stressed when on-call as I didn’t know when or where he would turn up. His family were very prominent in the community but I didn’t feel as though I could talk to them about any potential risk. I suppose I simply didn’t know how to broach the subject and everything I knew was hearsay. I did in fact attend his home to collect and ‘repair’ a woman he had allegedly assaulted with a heavy frypan but when I was called I was not informed that he was the perpetrator and was told he wasn’t home (technically true, he had run off into the bush after the incident). Again, no immediate threat to my safety but I became increasingly stressed and fearful when working on my own at night.

At about the same time I was asked to take on a new staff member who had been on extended sick leave following a violent physical attack at another community. This woman was deemed ‘ready’ to return to work and our community was viewed as the least violent and with the most support. I felt her anxiety at returning to work and I also felt ill prepared to provide the support she needed. We did not ‘hit it off’ either personally or professionally for a number of reasons but I think working with someone who had been through this and not ‘fully recovered’ was a constant reminder of the potential risk.

As a result of all this I wanted to ‘do something’ and had been quite vocal to my line managers about the risk of violence and lack of security for nurses. I was subsequently invited to meet with the NT health minister to discuss my concerns. The nurse manager from a neighbouring community accompanied me as she shared my concerns and I wanted the support. The meeting was definitely an interesting experience but there were other ‘officials’ present who seemed eager to dismiss and explain away our concerns. I left feeling as though I hadn’t been heard.

So in regards to the topic for my thesis, I have an obvious bias towards the idea that the level of risk is unacceptable and that something needs to be done about it. I think

that working alone at night and leaving the clinic for call outs are the riskiest aspects of being a RAN. I also feel that it is not taken seriously enough by those in power. I acknowledge that these are my concerns and they may not be shared by the panel. The panel is likely have other concerns that are more pressing to them and as a researcher I need to make a conscious effort to describe and analyse the information accurately and reflect the panels views and not my own.