NURSES AND OCCUPATIONAL VIOLENCE: THE ROLE OF ORGANISATIONAL SUPPORT IN MODERATING PROFESSIONAL COMPETENCE

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ABSTRACT

Objective

Occupational violence as experienced by professional nurses has been extensively researched. However, the majority of studies have focused primarily on psychological and emotional outcomes and have not identified any interventions that may reduce the impact of aggressive behaviour on professional competence. The purpose of this study was to investigate the relationship between organisational support, occupational violence and perceived professional competence of professional nurses in Australia.

Design:

A model testing research design was used to test the hypothesis that organisational support, as experienced by nurses, would moderate the relationship between occupational violence and perceived professional competence.

Setting:

Nurses registered in Division 1 of the Nurses Board (Victoria, Australia).

Participants:

A systematic random sample of 380 registered nurses from the target population of nurses in Victoria was identified.

Main outcome measure:

The relationship between organisational support, occupational violence and perceived professional competence of professional nurses in Australia.

Results:

The result showed that there was a significant effect of occupational violence on perceived competence. Analysis of the moderating effect of organisational support on the relationship between occupational violence and professional competence showed there was significant organisational support and occupational violence interaction. Overall, the data analysis demonstrated the hypothesis was upheld that the negative effects of occupational violence on perceived professional competence will be moderated by perceived organisational support.

Conclusions:

The failure to receive appropriate organisational support may result in lowering professional nurses' competence levels, causing a significant problem for the profession in that a reduction in professional competence has significant implications for patient care. The findings heighten the responsibility of the nursing profession to become more aware of the needs of professional nurses.

INTRODUCTION

A report by Perrone (1999) for the Australian Institute of Criminology showed the health industry to be the most violent industry in Australia, with registered nurses (RNs) recording the second highest number of violence-related workers compensation claims in 1995/96, ranking higher than prison and police officers. Zernike and Sharpe (1998) reported that nurses at the Royal Brisbane Hospital, Australia, felt they had become acclimatised to aggressive behaviour and accepted it as part of the nature of nursing work. Wells and Bowers (2002) conducted a literature review and critical analysis on occupational violence and reported that the best available evidence indicates an incidence of more than 9.5% of general nurses working in general hospitals being assaulted in any one year.

The phenomenon of occupational violence as a stressor has been observed to have extensive detrimental effects on the psychological, social, emotional and physical wellbeing of nurses (Bowie 1996; Mason and Chandley 1999; Turnbull and Paterson, 1999). Of equal importance is the fact that negative effects of occupational violence have contributed to changes in how nurses perceive their own professional competence (Rippon 2000; Whittington and Wykes 1992; Wykes and

Whittington 1994). Nurses have been reported as experiencing different consequences to aggression than other health and non-health occupations, as nurses must continue to perform their duty of care and whilst so doing, maintain their professional competence while delivering health care to patients (Mason and Chandley 1999). Mason and Chandley also claim that although many nurses, despite wanting to talk to someone about being assaulted, felt unsupported by co-workers and hospital administration. Rippon (2000) draws attention to the difficulty of researching this sensitive topic as victims are frequently traumatised and emotional support has been limited or non-existent.

The role of support

Accessing and utilising support has been identified as a key strategy for coping with stressors (DeLongis et al 1988; Lazarus and Folkman 1984; Folkman 1984). This body of knowledge supported the proposition that support has either a direct effect or a moderating effect on psychological distress across a variety of contexts. However, Paterson et al (1999) draw attention to the failure of organisations to provide support to nurses who have experienced work-related aggression. Rose (in Rippon 2000) reported that only 29% of nurses in an accident and emergency department reported physical assaults because they believed that reports by private citizens received more support than those of nurses. Paterson et al (1999) state that any attempt to provide support may need to overcome the attitude, historically prevalent in nursing, that to access support indicates a need for support, which is interpreted as professional failure. They suggest that the nature of the organisational response to the traumatised staff member can play a pivotal role in the process of recovery and, where the organisational response fails to understand or consider the needs of the victim, can constitute a source of secondary injury or trauma.

Given that support has been proposed as providing a potential moderating influence by several authors (Caplan 1974; Cobb 1976; House 1981), it was decided to test the moderating effect of organisational support on work-related aggression as it impacts upon perceived professional competence of RNs in Australia.

The definition for aggression utilised in this study was offered by Campbell and Landenburger (1996, p.732) as: 'those nonaccidental acts, interpersonal or intrapersonal, that result in physical or psychological injury to one or more persons'. This definition focuses on the relationships between people involved in occupational violence and may include the different roles and power relationships people have within the organisation.

Types and sources of occupational violence

The sources of occupational violence include patients and their relatives, medical staff and co-workers including senior nursing staff (Farrell 1999; 2001). Occupational violence may take the form of verbal abuse, (Cameron 1998) psychological bullying (Farrell 1996), sexual assault (Madison 1997; Madison and Gates 1996) or physical threats (Croker and Cummings 1995). It can come from a variety of sources, including patients and/or their relatives, doctors, administrators or colleagues (Carmel and Hunter 1991; Diaz and McMillin 1991; Holden, 1985).

Farrell (1999), in a survey of 270 Australian nurses in Tasmania, found that approximately 41% of public sector respondents and 62% of private sector respondents indicated that aggression caused them distress at work, with aggression from colleagues being most commonly cited by both groups of respondents.

Impact of occupational violence

Occupational violence has been shown to have negative effects on individual nurses and on the nursing profession (Bowie 1996, 2000; Farrell 1997; Patterson et al 1999). Janoff-Bulman (1989) suggested that being a victim of occupational violence has the potential to destroy one's perception of, and ability to function in, a stable and orderly world. Consequently, when a violent incident occurs, the victim's professional and personal world no longer feels familiar; this has the potential to impact upon how nurses' perceive their own professional competency.

Professional competency

Competency is a concept familiar to most nurses. To a large extent it becomes symbolic of academic and clinical achievement and can become enshrined as a professional ideal to which nurses must aspire. An understanding of how competency is applied to nursing in terms of standards is enhanced by consideration of competency as a psychological construct. Competence has been widely discussed in the psychological literature in terms of environmental mastery (Jahoda 1958), ability to cope with difficulties (Bradburn 1969), and self-efficacy or expectations of mastery (Bandura 1977). A competent person, according to Warr (1990, p.197), 'is one who has adequate psychological resources to deal with experienced difficulties'.

Competency is an important construct in professional training and registration in nursing. Potter and Perry (1993, p.327) defined competency in this context as the 'overall perceptions of nurses regarding quality of functioning in delivering effective, direct patient care'. The significance of this definition lies in the use of the words 'perceptions of nurses,' as it clearly moves the assessment of competence from an external source to the internal, subjective domain.

Organisational support

A supportive work environment has been proposed as a coping strategy or moderator, buffering the individual from the damaging effects of work stressors such as occupational violence (Payne 1979, in Mackay and Cox

1979). For example, a study by Quine (1999), conducted on health workers in England, found that a supportive work environment can protect people from some of the harmful effects of bullying. However, in the health industry, the work environment is not necessarily supportive. Nurses who experience occupational violence may be encouraged to not report or discuss aggressive incidents, thereby closing off possible sources of support, and, as a consequence, suffer more intensely. Further, culturally based values and beliefs embedded in the nursing profession may inhibit nurses from reporting aggression and making optimal use of available coping resources.

Conceptual framework

The stress model of cognitive appraisal (Lazarus and Folkman 1984) is integrated within a conceptual framework based on the notion of organisational support as a moderating influence on the relationship between nurses' experience of occupational violence and their perceived professional competence. The proposition that cognitive processes moderate the individual's responses to the environment has been widely accepted in the stress literature (Folkman et al 1986).

According to Gazzaniga (1988, p.996), threat has more to do with the idea of control: '…people can't, or think they can't, control their immediate environment'. DasCupta (1992) claimed that a perceived lack of control is just as important as an actual loss of control in causing us to feel threatened. A person's sense of control in any situation also comes from believing that it is possible to reach desired goals. Bandura (1977) similarly observed, that it is threatening for a person to feel that he or she lacks competence to cope with a particular demand.

The proposed moderating relationship between occupational violence, organisational support and perceived competence is represented in figure 1 as a path diagram.

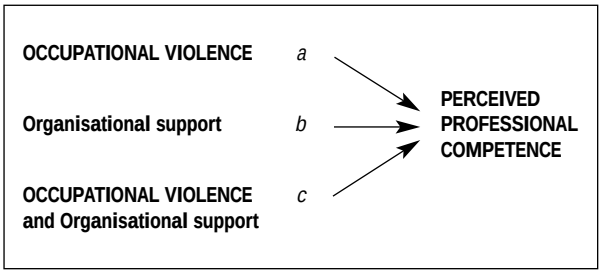

Figure 1: Model of the moderating effect of organisational support on occupational violence and perceived changes to professional competence

Figure 1 has three causal paths that feed into the outcome variable of perceived professional competence. The impact of occupational violence as a predictor (Path a), the impact of organisational support as a moderator (Path b), and the interaction or product of these two (Path c). The moderator hypothesis is supported if the interaction (Path c) is significant.

Examination of the literature suggested that while some studies have identified important physical, psychological and emotional aspects of how nurses respond to work-related aggression, the most significant gap in the research literature was the absence of studies investigating the role of organisational support in moderating the impact of occupational violence on perceived professional competence of RNs. As evident in the empirical literature in this field, there is a need to investigate the effect of organisational support in moderating the potential negative impact of occupational violence on perceived professional competence.

Aims of the study

The purpose of this study was to test the hypotheses that organisational support, would moderate the relationship between occupational violence and perceived professional competence of professional nurses in Australia.

METHOD

A survey was used to collect data that tested the moderating effect of organisational support on RNs perceptions of their professional competence following their experience of occupational violence. The researcher used Principal Component Analyses and a Content Validity Index to develop an instrument with 27 items requesting data on nurses experience of occupational violence, eight items on supporting behaviours from the organisation and 16 items on nurses' perceptions of their professional competence. Following a pilot study, 504 questionnaires were posted to registered nurses (RN Division 1) who were registered with the Nurses Board of Victoria, Australia.

Sample of registered nurses

A systematic random sample from the target population of nurses in Victoria was identified. The researcher utilised a Power Analysis procedure to estimate that a sample size of 380 nurses in Victoria was sufficient to test the hypothesised model. Ethics approval was granted from the university ethics committee and consent was implied through the return of completed questionnaires.

RESULTS

Results from the survey showed: the mean age of subjects was 39.18 (SD 10.61).

263 subjects (69.6%) were employed in urban facilities and 115 (30.4%) in rural communities. The mean years of experience as an RN was reported as 16 years (SD 9.61). 361 subjects (93% of the sample of 387), made a total of 2,755 responses to having experienced verbal, sexual and physical aggressive incidents from doctors, nurse colleagues and patients.

Verbal aggression (89%) was the most frequent type of work related aggression reported, followed by 77% reporting physical aggression, and 47% reporting sexual aggression. Patient initiated aggression was the most common source of aggression, with 88%, followed by 71% from doctors, and 61% from nurse colleagues.

There was an overall perception by 70 nurses who experienced occupational violence that nurse managers were 'not interested in their own [respondents] wellbeing', and 58 nurses perceived managers as 'not actively supportive'. For the aggregate score of organisational support the results showed that there was a significant effect [t(df=313)=2.54, p<0.025)], and that occupational violence impacted negatively on perceptions of supporting behaviours of key organisational staff.

A t-test was conducted between two categories of high and low scores for occupational violence and perceived professional competence. The result showed that there was a significant effect [t(df=382)=-3.05, p<0.002)] of occupational violence on perceived competence. Results of the regression analyses of the moderating effect of organisational support on the relationship between occupational violence and professional competence showed that there was significant organisational support and occupational violence interaction. Overall, the data analysis demonstrated that the hypothesis was upheld that the negative effects of occupational violence on perceived professional competence will be moderated by perceived organisational support.

Figure 2: Organisational support as a moderator of the relationship between occupational violence and perceived professional competence

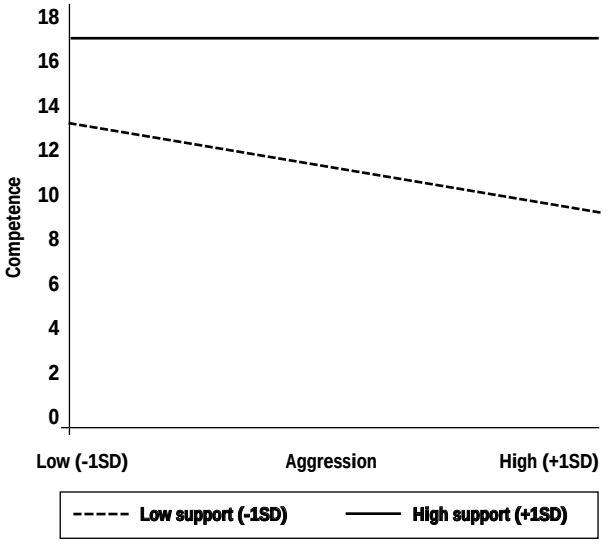

Figure 2 shows the occupational violence and organisational support interaction. For this graph, the effects of organisational support and occupational violence on perceived professional competence were plotted at two points: high and low. The slope for high organisational support was not significant [b= -0.02, t(df=308)= 0.28,ns], while the slope for low organisational support was significant [b=-0.26, t(df=308)=-3.68, p<0.001]. As noted, the rate of effect of occupational violence on perceived professional competence is more at low organisational support than high organisational support. This suggests that organisational support moderates the effect of occupational violence on perceived professional competence.

When organisational support was received, it was provided mostly by nurse colleagues who were seen as very supportive. Doctors were generally considered to be either slightly or not at all supportive and scored lowest in organisational support. In the main, managers scored in the middle ranges of slightly to moderately supportive.

DISCUSSION

These findings heighten the responsibility of the nursing profession and health organisations for the welfare of nurses employed in general nursing settings. Results have highlighted the importance of training nurses and nurse managers to provide organisational support to nurses who have been victims of occupational violence.

Nurse managers should receive comprehensive and carefully focused training in how to support the role of RNs; for example, by encouraging and promoting professional autonomy, decision making and control over practice.

The results in this study clearly show the provision of formal organisational support may prevent, or at least reduce, a decrease in nurses' perceived professional competence. Differences were found between high and low levels of organisational support, with high levels associated with higher levels of perceived professional competence and low levels associated with low levels of perceived professional competence, indicating that organisational support moderated the effect of occupational violence.

From the findings of this study, there is no doubt that the provision of organisational support plays an important role in moderating the impact of occupational violence on perceived professional competence, thereby giving further credence to the theory of cognitive appraisal postulated by Lazarus and Folkman (1984). Conversely, the failure to receive appropriate organisational support can result in lowering nurses' professional competence levels causing a significant problem for the profession in that a reduction in professional competence has significant implications for patient care. Nurses who have experienced occupational violence may become cynical about nursing, complaining about lack of collegial support from within the profession. They may become reluctant to establish and maintain contact with aggressive patients and staff and thereby compromise the quality of care delivered to patients regardless of whether they are perpetrators or not.

Perhaps the most important implication is that the profession, as a whole, should become aware of the extent of occupational violence and its impact on professional competence, and the role that nurse colleagues, nurse managers and medical staff play in its genesis. Some of the staff who have been implicated in this study as aggressors may have little or no understanding of the effect of their behaviour on others. It may be the case that nurse managers, who may well have been victims, are unaware of how to manage and support nurses who experience occupational violence. As a preliminary intervention, nursing administrators could make themselves more available to staff who have experienced occupational violence.

It is uncertain whether senior nurse administrators are aware of the extent of the problem of occupational violence and more importantly, aware of their own role in its perpetuation. Nursing administrators should become more aware of the personal needs of the victim, as well as the needs of the organisation or the profession. They should specifically consider the relationship between strategies utilised by managers for assisting new nurses to come to terms with aggressive behaviour from a variety of sources.

CONCLUSION

Although it is unlikely the nursing profession will ever reduce occupational aggression to zero, reducing its professional impact should be a first priority for nursing administrators. Before this can be achieved there is a need by the profession to acknowledge and claim ownership of the psychological injury experienced by its members. Therefore, a professional nursing culture that acknowledges its own contribution to the problem can contribute to individual and professional recovery. Future research should be directed toward identifying and testing interventions which may prevent, or at least reduce the impact of occupational violence on nurses.

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